EXHIBIT "D"

DR. KAPLAN'S ENTIRE MEDICAL CHART ON PLAINTIFF

HANDWRITTEN NOTES CREATED IN PREPARATION FOR

AUGUST 25, 2017 DEPOSITION

No prior.
~~Ericksen~~

Dizzy
head
C/L
L/R shoulder
L/R hips/knee/ankle/feet
Lip twitch

HTN / ↑chol
fibromyalgia
arthritis Back/knees
C/L
hip bursitis
Bilat sciatica

Mobic
Gabapentin
Lido patch
morphine
Tylenol

SSI

? Sx

C - 10/10 → 20
40/40 → 30 → 50 → 60
10 → 20
L - 30/10 → 40 → 45
10/10 - 20 ...

(shoulder) - Sh 110 (R>L) → 140 / 110 → 150
50/50 → 60
⊕ imp

Hip - 90/70 → 100
K - 0 → 110 (L>R) → 115 → 115
ankle - 15/30 → 30/35
10/5

↑ thigh UE (L)
↑ (L) shoulder → ↓ motion weakness

Phalen

No meds
PT
Cane
TENS / LSO / C-traction
knee brace

++ (prior ⊕)
C/L MRI
?TP - x/15 Rt sh inj / LT sh, C/L TP x2
C/L EMG ++
Rt sh + LT sh
LT knee +
L/R hip
Rt knee / LT foot - plantar/CA

Fx? Moise / Scilaris) Skeletal mast
Feldon - No Sx

Lempert
L-epidurals / MBB x2
L knee Sx - 11/29/16
R knee Sx ~ 3/16/17
C-epidural / MBB

4/17

DR. KAPLAN'S OFFICE AND PROCEDURE NOTES

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Date: May 12, 2015

RE: Falero, Diana

INITIAL EVALUATION

History / Chief Complaints: This patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees and ankles and feet. She went by ambulance to Kings County Hospital. She states she had x-rays of the areas and reportedly there was no fracture. She states she was given a tetanus shot. She also complains of twitching in the right upper lip on and off since the injury. She denies any change in vision or hearing change or smell or taste. She has constant back pain and stiffness. She has constant pain in both shoulders and difficulty lifting them over the head. She has constant pain and stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse.

Past Medical History: She has multiple prior medical conditions including high blood pressure, elevated cholesterol, fibromyalgia, arthritis of the back and knees, herniated cervical and lumbar disks, bursitis in the hips, bilateral sciatica.

Past Surgical History: Foot surgery 1991, 2005. Tubal ligation

Medications: See intake list includes Mobic, Robaxin, Lidoderm patches, Morphine 60 mg 3 times a day, Zoloft, Simvastatin, Amlodipine.

Allergies: Negative.

Review of Systems: She denies alcohol abuse. She smokes a few cigarettes per. She states she's been on disability. She states she is separated.

Physical Exam: She has a slow gait and appears to be in discomfort. She has difficulty moving about exam table. There is no ecchymosis of the head. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right 40°, left and right side bending 10°. Lumbar flexion 30°, extension 10°, left and right side bending 10°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Bilateral shoulder flexion and abduction are 110°. Internal and external rotation 50°. There is mild positive impingement sign at both shoulders. Otherwise strength is intact and shoulders. Elbow and wrist range

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of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation 10° with pain. There is full extension of both knees and flexion is 110° bilaterally. There is mild crepitus in the knees. Lachman test is negative. McMurray's test is negative. There is mild edema at both ankles laterally with mild tenderness. There is bilateral ankle dorsiflexion at 15°, plantar flexion 30°, inversion 10°, and eversion 5. There is tenderness on the dorsum of both feet. Sensation is grossly intact extremities.

Impression: 65-year-old right-handed status post injury on May 4, 2015. Post-traumatic headache, cervical and lumbar derangement, bilateral shoulder derangement, bilateral hip, and knee and ankle derangement.

Plan: She will attend PT 2x/ week and the program was reviewed with her. She will undergo computer range of motion studies. I will not prescribe any medications as she already takes several. She will follow up in 4 weeks. We will try and obtain prior records.

Sincerely,

Charles A. Kaplan, M.D.

CK:cn, Astoria

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Date: June 9, 2015

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees and ankles and feet. She went by ambulance to Kings County Hospital. She states she was given a tetanus shot. She also complains of twitching in the right upper lip on and off since the injury. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit.

Physical Exam: She has a slow gait and appears to be in discomfort. She is using a cane. She has difficulty moving about exam table. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Lumbar flexion is 30°, extension is 10°, left and right side bending is 10°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Bilateral shoulder flexion and abduction are 110°. Internal and external rotation is 50°. There is mild positive impingement sign at both shoulders. Otherwise strength is intact and shoulders. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 110° bilaterally. There is mild crepitus in the knees. Lachman's test is negative. McMurray's test is negative. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion 30°, inversion is 10°, eversion is 5°. There is tenderness on the dorsum of both feet. Sensation is grossly intact extremities.

Assessment/Plan: She will attend physical therapy 2x/ week. I am referring her for cervical and lumbar MRI. I discussed trigger point injections. She is not sure she would want that as in the past she had with another physician and she felt very sore from it but it did help. I will not prescribe any medications as she already takes several. She will follow up in 2-3 weeks. I ordered TENs for her. We will try and obtain prior records.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea - Brooklyn

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Date: July 2, 2015

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENs now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations –see report- a prior lumbar MRI of 2013 did not reveal any disc injuries.

Physical Exam: She has a slow gait and appears to be in discomfort. She is using a cane. She has difficulty moving about exam table. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Lumbar flexion is 30°, extension is 10°, left and right side bending is 10°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Bilateral shoulder flexion and abduction are 110°. Internal and external rotation is 50°. There is mild positive impingement sign at both shoulders. Otherwise strength is intact and shoulders. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 110° bilaterally. There is mild crepitus in the knees. Lachman's test is negative. McMurray's test is negative. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion 30°, inversion is 10°, eversion is 5°. There is tenderness on the dorsum of both feet. Sensation is grossly intact extremities.

Assessment/Plan: She will attend physical therapy 2x/ week. I am referring her for cervical and lumbar EMG. I discussed trigger point injections -She is not sure she would want that as in the past she had with another physician and she felt very sore from it but it did help. I am referring her for right shoulder, left

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knee and bilateral hip MRI. I will not prescribe any medications as she already takes several. She will follow up in five weeks. She will continue TENs. I prescribed LSO and cervical traction. We will try and obtain prior records.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
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Date: August 25, 2015

Re: Falero, Diana

Ultrasound Guided Trigger point injections

The patient presents today for ultrasound-guided trigger point injections of the right and left L3 and L5 paraspinals .

Permit: The injection, risks, and benefits were explained to the patient who expressed verbal understanding and wished to proceed.

Procedure: Using palpation, a total of 4 trigger points were identified in the lumbar region. The area was marked and the skin was prepped using alcohol. Using ultrasound guidance, a 22-gauge 1-1/2 inch needle was advanced causing a twitch response in the trigger points. A total of 4 ml of 0.25% Marcaine plus 1cc of 1% lidocaine was injected into the identified trigger points after negative aspiration. Pressure was applied until hemostasis was obtained. The patient tolerated the procedure well and there were no complications during or after the procedure. The patient was advised to ice the area for ten minutes

The patient will follow up as previously recommended.

Sincerely,

Charles Kaplan MD

CK:ea
Brooklyn

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Date: September 3, 2015

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENs now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations –see report- a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear- see report. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes –see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report.

Physical Exam: She has a slow gait. She is using a cane. She has difficulty moving about exam table. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Lumbar flexion is 30°, extension is 10°, left and right side bending is 10°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Bilateral shoulder flexion and abduction are 110°. Internal and external rotation is 50°. There is mild positive impingement sign at both shoulders. Otherwise strength is intact and shoulders. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 110° bilaterally. There is mild crepitus in the knees. Lachman's test is negative. McMurray's test is negative. There is mild edema at both ankles

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laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion 30°, inversion is 10°, eversion is 5°. There is tenderness on the dorsum of both feet. Sensation is grossly intact in extremities.

Assessment/Plan: She will attend physical therapy 2x/ week. I am referring her for a cervical and lumbar EMG. I will not prescribe any medications as she already takes several. I am referring her to Dr. Moise for further evaluation of the spine. I am also referring her to Dr. Scilaris for orthopedic evaluation She will follow up with me in five weeks. She will continue TENs. She will continue LSO and cervical traction. We will try and obtain prior records.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
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Date: October 8, 2015

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENs now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first.

She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations –see report- a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear- see report. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes –see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report.

Physical Exam: She has a slow gait. She is using a cane. She has difficulty moving about exam table. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Lumbar flexion is 30°, extension is 10°, left and right side bending is 10°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Bilateral shoulder flexion and abduction are 110°. Internal and external rotation is 50°. There is mild positive impingement sign at both shoulders. Otherwise, strength is intact and shoulders. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips

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Assessment/Plan: She will attend physical therapy 2x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise for epidurals, starting with the lumbar. She will follow up with Dr. Scilaris after getting the epidurals. She will follow up with me in five weeks. She will continue TENs. She will continue LSO and cervical traction. We will try and obtain prior records.

Sincerely,

Charles A. Kaplan, M.D.

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Date: November 20, 2015

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENs now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes –see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report.

Physical Exam: She is using a cane. She has mild difficulty moving about exam table. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Lumbar flexion is 30°, extension is 10°, left and right side bending is 10°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Bilateral shoulder flexion and abduction are 110°. Internal and external rotation is 50°. There is mild positive impingement sign at both shoulders. Otherwise, strength is intact and shoulders. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 110° bilaterally. There is mild crepitus in the knees. Lachman's test is negative. McMurray's test is negative. There is mild edema at both ankles laterally

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with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion 30°, inversion is 10°, and eversion is 5°. There is tenderness on the dorsum of both feet. Sensation is grossly intact in extremities.

Assessment/Plan: She will attend physical therapy 1x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise as needed. She will follow up with Dr. Scilaris as needed. She will follow up with me in 3 months. She will continue TENs. She will continue LSO and cervical traction. We will try and obtain prior records.

Sincerely,

Charles A. Kaplan, M.D.

CK:cn
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Date: February 25, 2016

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENs now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She feels her neck pain and left shoulder pain are worse the last 2-3 weeks. She has more tingling in both arms. She cannot sleep on the left shoulder. Her motion is more limited on the left.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes –see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report.

Physical Exam: She is using a cane. She has mild difficulty moving about exam table. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Left and right rotation are 30°. Lumbar flexion is 30°, extension is 10°, left and right side bending is 10°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. right shoulder flexion and abduction are 110°. Internal and external rotation is 50°. Left shoulder flexion and abduction are 90°- worse, IR and ER are 50°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 4+/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 110° bilaterally. There is mild crepitus

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in the knees. Lachman's test is negative. McMurray's test is negative. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 30°, inversion is 10°, and eversion is 5°. There is tenderness on the dorsum of both feet. Sensation is grossly intact in extremities.

Assessment/Plan: She will attend physical therapy 1x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise as she states she is interested in epidurals now. I am referring her for left shoulder MRI. She will follow up with Dr. Scilaris as needed. She will follow up with me in 6-8 weeks. She will continue TENs. She will continue LSO and cervical traction.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
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Date: April 6, 2016

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury.

She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENs now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She feels her neck pain and left shoulder pain are worse the last 2-3 months. She has more tingling in both arms. She cannot sleep on the left shoulder. Her motion is more limited on the left. She recently saw Dr. Moise who recommended trigger point injections.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report

Physical Exam: She is using a cane. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Left and right rotation are 40°. Lumbar flexion is 30°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. right shoulder flexion and abduction are 110°. Internal and external rotation is 50°. Left shoulder flexion and abduction are 90°, IR and ER are 50°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 4+/5.

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Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 110° bilaterally. There is mild crepitus in the knees. Lachman's test is negative. McMurray's test is negative. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 30°, inversion is 10°, and eversion is 5°. There is tenderness on the dorsum of both feet. Sensation is grossly intact in extremities.

Assessment/Plan: She will attend physical therapy 1x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise as recommended. I reviewed and she would like to undergo shoulder bursae injections and trigger point injections- this will be set up for the next 1-2 weeks. She will follow up with Dr. Scilaris as needed. She will follow up with me in 6-8 weeks. She will continue TENs. She will continue LSO and cervical traction.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
Brooklyn

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Date: April 7, 2016

Re: Falero, Diana

Ultrasound Guided left and right subacromial bursae injection

Permit: The injection, risks and benefits were explained to the patient who expressed verbal understanding and wished to proceed.

Procedure: Separate syringes were used for each shoulder.

The area was marked and the skin was prepped using alcohol. Using ultrasound guidance, a 25-gauge 1-1/2 inch needle was advanced from a lateral approach. A total of 1 ml of 0.25% Marcaine plus 1cc of 1 % lidocaine plus 40 mg depomedrol was injected from a lateral approach. Pressure was applied until hemostasis was obtained. The patient tolerated the procedure well and there were no complications during or after the procedure. The patient was advised to ice the area tonight for ten minutes.

The patient will follow up in three weeks.

Sincerely,

Charles Kaplan MD

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Date: April 14, 2016

Re: Falero, Diana

Ultrasound Guided Trigger point injections

The patient presents today for ultrasound-guided trigger point injections of the cervical and lumbar regions .

Permit: The injection, risks, and benefits were explained to the patient who expressed verbal understanding and wished to proceed.

Procedure: Using palpation, a total of 6 trigger points were identified in the left and right upper trapezius, C5 and L5 paraspinals_region. The area was marked and the skin was prepped using alcohol. Using ultrasound guidance, a 25-gauge 1-1/2 inch needle was advanced causing a twitch response in the trigger points. A total of 5 ml of 0.25% Marcaine plus 1cc of 1 % lidocaine was injected into the identified trigger points after negative aspiration. Pressure was applied until hemostasis was obtained. The patient tolerated the procedure well and there were no complications during or after the procedure. The patient was advised to ice the area tonight for ten minutes.

The patient will follow up in three weeks.

Sincerely,

Charles Kaplan MD

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Date: June 1, 2016

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENs now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She feels her neck pain and left shoulder pain are worse the last 2-3 months. She has more tingling in both arms. She cannot sleep on the left shoulder. Her motion is more limited on the left. She recently saw Dr. Moise who recommended trigger point injections. She had cervical and lumbar trigger point injections and bilateral shoulder bursae injections with mild benefit for 1-2 weeks.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report.

Physical Exam: She is using a cane. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Left and right rotation are 40°. Lumbar flexion is 30°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 110°. Internal and external rotation is 50°. Left shoulder flexion and abduction are 90°, IR and ER are 50°. There is mild

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positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 4+/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 110° bilaterally. There is mild crepitus in the knees. Lachman's test is negative. McMurray's test is negative. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 30°, inversion is 10°, and eversion is 5°. There is tenderness on the dorsum of both feet. Sensation is grossly intact in extremities.

Assessment/Plan: She will attend physical therapy 1x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise next week. She will follow up with Dr. Scilaris as needed. She will follow up with me in 6-8 weeks. She will continue TENs. She will continue LSO and cervical traction.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
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Date: July 27, 2016

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She feels her neck pain and left shoulder pain are worse the last 2-3 months. She has more tingling in both arms. She cannot sleep on the left shoulder. Her motion is more limited on the left. She recently saw Dr. Moise who recommended trigger point injections. She had cervical and lumbar trigger point injections and bilateral shoulder bursae injections with mild benefit for 1-2 weeks. She had a follow up with Dr. Moise and is awaiting procedures. She feels she would consider shoulder or knee surgery due to the pain. The right knee and left foot pain are a little worse. Her pains range from 5-9/10.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report.

Physical Exam: She is using a cane and ambulates slowly. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Left and right rotation is 50°. Lumbar flexion is 40°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 110°. Internal and external rotation is 60°. Left shoulder flexion and abduction are 100°, IR and ER

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are 50°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 4+/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° bilaterally. There is mild crepitus in the knees. Lachman's test is negative. McMurray's test is negative. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 1x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise for injections/nerve blocks. I am referring her for right knee and left foot MRI. She will follow up with Dr. Scilaris mostly about the shoulders and knees. She will follow up with me in 6-8 weeks. She will continue TENS. She will continue LSO and cervical traction.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
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Date: September 22, 2016

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often.

She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She has tingling in both arms. She cannot sleep on the left shoulder. Her motion is more limited on the left. She recently saw Dr. Moise who recommended trigger point injections. She had cervical and lumbar trigger point injections and bilateral shoulder bursae injections with mild benefit for 1-2 weeks. She had a follow up with Dr. Moise and is awaiting procedures. She feels she would consider shoulder or knee surgery due to the pain. The right knee and left foot pain are a little worse. Her pains range from 5-9/10. Dr. Scilaris recently recommended surgery to the left knee.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report. Right knee MRI revealed femoral condyle compression fracture, bone contusion, medial meniscal tear, partial ACL tear, gastrocnemius tear –see report. Left foot MRI revealed post op changes, OA of the first toe, hammer toes, neuroma-see report.

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Physical Exam: She is using a cane and ambulates slowly. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Left and right rotation is 50°. Lumbar flexion is 40°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 110°. Internal and external rotation is 60°. Left shoulder flexion and abduction are 110°, IR and ER are 50°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 4+/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° bilaterally. There is mild crepitus in the knees. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 1x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise for injections/nerve blocks. She will follow up with Dr. Scilaris for left knee surgery. I am referring her to Dr. Persich for the foot, or she will find a podiatrist closer to her house. She will follow up with me in six weeks. She will continue TENS. She will continue LSO and cervical traction. I prescribed bilateral soft knee braces.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
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Date: November 8, 2016

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 65-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She has tingling in both arms. She cannot sleep on the left shoulder. Her motion is more limited on the left. She recently saw Dr. Moise who recommended trigger point injections. She had cervical and lumbar trigger point injections and bilateral shoulder bursae injections with mild benefit for 1-2 weeks. She had a follow up with Dr. Moise and is awaiting procedures. She feels she would consider shoulder or knee surgery due to the pain. The right knee and left foot pain are a little worse. Her pains range from 5-9/10. Dr. Scilaris recently recommended surgery to the left knee. She recently had lumbar epidural and feels some benefit. She is to have cervical epidural later this week.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report. Right knee MRI revealed femoral condyle compression fracture, bone contusion, medial meniscal tear, partial ACL tear, gastrocnemius tear –see report. Left foot MRI revealed post op changes, OA of the first toe, hammer toes, neuroma-see report.

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Margaret Zakhary, RPA-C
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Charles A. Kaplan, M.D.
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Thomas Scilaris, M.D.
Orthopaedic Surgery
Board Certified, ABOS

Physical Exam: She is using a cane and ambulates slowly and uses knee brace. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 10°, left and right side bending is 20°. Left and right rotation is 50°. Lumbar flexion is 40°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 110°. Internal and external rotation is 60°. Left shoulder flexion and abduction are 110°, IR and ER are 50°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 4+/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° bilaterally. There is mild crepitus in the knees. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 1x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise for injections/nerve blocks. She will follow up with Dr. Scilaris for left knee surgery. I am referring her to Dr. Persich for the foot, or she will find a podiatrist closer to her house. She will follow up with me in six weeks. She will continue TENS. She will continue LSO and cervical traction. I prescribed bilateral soft knee braces.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
Brooklyn

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Thomas Scilaris, M.D.
Orthopaedic Surgery
Board Certified, ABOS

Date: December 13, 2016

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 66-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting over head. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She has tingling in both arms. She cannot sleep on the left shoulder. Her motion is more limited on the left. She saw Dr. Moise who recommended trigger point injections. She had cervical and lumbar trigger point injections and bilateral shoulder bursae injections with mild benefit for 1-2 weeks. She had a follow up with Dr. Moise and is awaiting procedures. She feels she would consider shoulder or knee surgery due to the pain. The right knee and left foot pain are a little worse. Her pains range from 5-9/10. Dr. Scilaris recently recommended surgery to the left knee- she had the surgery on 11/29/16 and is in post op physical therapy. She feels only mild pain in the knee from the surgery. She recently had lumbar epidural and feels some benefit.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report. Right knee MRI revealed femoral condyle compression fracture, bone contusion, medial meniscal tear, partial ACL tear, gastrocnemius tear –see report. Left foot MRI revealed post op changes, OA of the first toe, hammer toes, neuroma-see report.

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Thomas Scilaris, M.D.
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Date: December 13, 2016
RE: Falero, Diana
Page 2 of 2

Physical Exam: She is using a cane and ambulates slowly and uses knee braces. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 20°, left and right side bending is 20°. Left and right rotation is 50°. Lumbar flexion is 40°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 110°. Internal and external rotation is 60°. Left shoulder flexion and abduction are 110°, IR and ER are 60°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 4+/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° on the right and 100 degrees on the left. Left knee portal scars mostly healed with steristrip. There is mild crepitus in the right knee. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 3x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise for injections/nerve blocks. She will follow up with Dr. Scilaris. I am referring her to Dr. Persich for the foot. She will follow up with me in six weeks. She will continue TENS. She will continue LSO, cervical traction and bilateral soft knee braces.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
Brooklyn

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Thomas Scilaris, M.D.
Orthopaedic Surgery
Board Certified, ABOS

Date: February 1, 2017

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 66-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting overhead. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She has tingling in both arms. She cannot sleep on the left shoulder. She saw Dr. Moise who recommended trigger point injections. She had cervical and lumbar trigger point injections and bilateral shoulder bursae injections with mild benefit for 1-2 weeks. She feels she would consider shoulder or knee surgery due to the pain. The right knee and left foot pain are a little worse. Dr. Scilaris recommended surgery to the left knee- she had the surgery on 11/29/16 and is in post op physical therapy. She feels only mild pain in the knee from the surgery. She recently had lumbar epidural and feels some benefit. She feels her lower back pain is 8/10. The neck pain is 7/10. She feels lower left and right shoulder and left and right ankle and feet are mild. The right knee pain is 5 / 10. Left knee pain is 3-5 / 10. She had epidurals with Dr. Moise and MBB. Her foot pain is mild so we agreed she does not need to see Dr. Persich.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report. Right knee MRI revealed femoral condyle compression fracture, bone contusion, medial meniscal tear, partial ACL tear, gastrocnemius tear –see report. Left foot MRI revealed post op changes, OA of the first toe, hammer toes, neuroma-see report.

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Date: February 1, 2017
RE: Falero, Diana
Page 2 of 2

Physical Exam: She is using a cane and ambulates slowly and uses knee braces. There is a mild positive Rhomberg. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 20°, left and right side bending is 20°. Left and right rotation is 60°. Lumbar flexion is 40°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 140°. Internal and external rotation is 70°. Left shoulder flexion and abduction are 140°, IR and ER are 80°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 5-/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° on the right and 110 degrees on the left. Left knee portal scars mostly healed with mild edema. There is mild crepitus in the right knee. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is mild tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 3x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise for injections/nerve blocks/RF. I am referring her to Dr. Faloon for further spine surgery opinion. She will follow up with Dr. Scilaris. She will follow up with me in six weeks. She will continue TENS. She will continue LSO, cervical traction and bilateral soft knee braces. I advised her to speak with her internist as she is having some issues with balance and a positive Romberg test

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
Brooklyn

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: 03/22/2017

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 66-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting overhead. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She feels the knee and shoulder are a little better and would not want surgery She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She has tingling in both arms. She cannot sleep on the left shoulder. She saw Dr. Moise who recommended trigger point injections. She had cervical and lumbar trigger point injections and bilateral shoulder bursae injections with mild benefit for 1-2 weeks. She feels she would consider shoulder or knee surgery due to the pain. The right knee and left foot pain are a little worse. Dr. Scilaris recommended surgery to the left knee- she had the surgery on 11/29/16 and attended post op physical therapy. She feels only mild pain in the knee since the surgery. She recently had lumbar epidural and feels some benefit. She feels her lower back pain is 8/10. The neck pain is 7/10. She feels lower left and right shoulder and left and right ankle and feet are mild. The right knee pain is 5 / 10. Left knee pain is 3-5 / 10. She had epidurals with Dr. Moise and MBB. Her foot pain is mild so we agreed she does not need to see Dr. Persich. She underwent right knee surgery about two weeks ago. She had follow-up with Dr. Scilaris and is to start physical therapy. She feels the right knee is already improving nicely.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon -see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report. Right knee MRI revealed femoral condyle compression fracture, bone contusion, medial meniscal tear, partial ACL tear, gastrocnemius tear –see report. Left foot MRI revealed post op changes, OA of the first toe, hammer toes, neuroma-see report.

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: March 22, 2017
RE: Falero, Diana
Page 2 of 2

Physical Exam: She is using a cane and ambulates slowly and uses knee braces. There is a mild positive Rhomberg. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 20°, left and right side bending is 20°. Left and right rotation is 60°. Lumbar flexion is 40°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 140°. Internal and external rotation is 70°. Left shoulder flexion and abduction are 140°, IR and ER are 80°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 5-/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 90° with end range pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° on the right and 110 degrees on the left. Left knee portal scars mostly healed with mild edema. There is mild crepitus in the right knee. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 15°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is mild tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 2-3x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise for injections/nerve blocks/RF. I am referring her to Dr. Faloon for further spine surgery opinion. She will follow up with Dr. Scilaris. She will follow up with me in six weeks. She will continue TENS. She will continue LSO, cervical traction and bilateral soft knee braces. I advised her to speak with her internist as she is having some issues with balance and a positive Romberg test.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
Brooklyn

54 South Dean Street
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100A Livingston Street
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SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: 05/03/2017

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 67-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often. She has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She has constant pain in both shoulders and difficulty lifting overhead. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels her right shoulder hurts more than the left. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. Ultrasound guided lumbar injections were helpful. She consulted with Dr. Moise who recommended epidurals. She consulted with Dr. Scilaris who initially recommended being treated with Dr. Moise first. She feels her back is a little better and would not want epidurals. She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She has tingling in both arms. She cannot sleep on the left shoulder. She saw Dr. Moise who recommended trigger point injections. She had cervical and lumbar trigger point injections and bilateral shoulder bursae injections with mild benefit for 1-2 weeks. Dr. Scilaris recommended surgery to the left knee- she had the surgery on 11/29/16 and attended post op physical therapy. She feels only mild pain in the knee since the surgery. She recently had lumbar epidural and feels some benefit. She feels her lower back pain is 5/10. The neck pain is 7/10. She feels lower left and right shoulder and left and right ankle and feet are mild. The right knee pain is 3-5 / 10. Left knee pain is 3-5 / 10. She had epidurals with Dr. Moise and MBB. Her foot pain is mild so we agreed she does not need to see Dr. Persich. She underwent right knee surgery on 3/16/17. She had follow-up with Dr. Scilaris and is in physical therapy. She feels the right knee is already improving nicely. She consulted with Dr. Faloon and conservative care was decided upon. She feels more pain radiating down the left arm the last week. She had lumbar RF with benefit. She had cervical epidural last week.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report. Right knee MRI revealed femoral condyle compression fracture, bone contusion, medial meniscal tear, partial ACL tear, gastrocnemius tear –see report. Left foot MRI revealed post op changes, OA of the first toe, hammer toes, neuroma-see report.

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: May 3, 2017
RE: Falero, Diana
Page 2 of 2

Physical Exam: She is using a cane and ambulates a little slowly. There is a mild positive Rhomberg. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 20°, left and right side bending is 20°. Left and right rotation is 60°. Lumbar flexion is 45°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 150°. Internal and external rotation is 80°. Left shoulder flexion and abduction are 150°, IR and ER are 80°. There is mild positive impingement sign at both shoulders. Spurling's is negative. Right shoulder MP is 5/5. Left shoulder MP is grossly 5-/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 100° with end range mild pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° on the right and 115 degrees on the left. Left knee portal scars mostly healed with mild edema. There is mild crepitus in the right knee. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 20°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is mild tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 2x/ week, mostly for the post op knee. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise. She will follow up with Dr. Scilaris later today. She will follow up with me in six weeks. She will continue TENS. She will continue LSO, cervical traction and bilateral soft knee braces. She may require left shoulder injection. I advised her to speak with her internist as she is having some issues with balance and a positive Romberg test- she has an appointment in two weeks.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
Brooklyn

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SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: May 22, 2017

Re: Falero, Diana

Ultrasound Guided left shoulder subacromial bursae injection

Permit: The injection, risks, and benefits were explained to the patient who expressed verbal understanding and wished to proceed.

Procedure: The area was marked and the skin was prepped using alcohol. Using ultrasound guidance, a 25-gauge 1-1/2 inch needle was advanced to the subacromial space from a lateral approach. A total of 1 ml of 0.25% Marcaine plus 1cc of 1 % lidocaine plus 40mg of depomedrol was injected after negative aspiration. Pressure was applied until hemostasis was obtained. The patient tolerated the procedure well and there were no complications during or after the procedure. The patient was advised to ice the area tonight for ten minutes and not to overuse the arm for two days.

The patient will follow up in three weeks.

Sincerely,

Charles A. Kaplan MD

CK:ea - Brooklyn

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Brooklyn NY 11201
T: 718-852-4300 F: 718-858-4265

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: 06/14/2017

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 67-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often. She still has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She feels her neck and back pain are both 8/10 on average on a pain scale. Ultrasound guided lumbar and cervical trigger point injections were helpful but temporary. She consulted with Dr. Moise who recommended epidurals. She recently had lumbar epidural and feels some benefit but has worn off. Her neck and back are a little worse the last month. She had epidurals with Dr. Moise and MBB. She consulted with Dr. Faloon and conservative care was decided upon. She feels more pain radiating down the left arm the last few weeks. She had lumbar RF with benefit. She had cervical epidural. She has constant pain in both shoulders and difficulty lifting overhead. The left shoulder is severe, around 8/10. The right shoulder is 2/10. She has tingling in both arms more on the left. She states she mentioned the balance issue to her internist but was not given a referral although neurology was reportedly discussed.

She does not work and has been on SSI since around 2007. She has not worked since 2002.

She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. She consulted with Dr. Scilaris who initially recommended being treated with Dr. Moise first. She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She cannot sleep on the left shoulder. She had bilateral shoulder bursae injections with mild benefit for 1-2 weeks. Dr. Scilaris recommended surgery to the left knee- she had the surgery on 11/29/16 and attended post op physical therapy. She feels only mild pain in the knee since the surgery. She feels the left and right ankle and feet are mild and not often. The right knee pain is 3 / 10. Left knee pain is 3-5 / 10. She underwent right knee surgery on 3/16/17. She had follow-up with Dr. Scilaris and is in physical therapy. She feels the right knee is already improving nicely. Bilateral hip pain is mild now.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report. Right knee MRI revealed femoral condyle compression fracture, bone contusion, medial meniscal tear, partial ACL tear, gastrocnemius tear –see report. Left foot MRI revealed post op changes, OA of the first toe, hammer toes, neuroma-see report.

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: June 14, 2017
RE: Falero, Diana
Page 2 of 2

Physical Exam: She is using a cane and ambulates a little slowly. There is a mild positive Rhomberg. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 20°, left and right side bending is 20°. Left and right rotation is 60°. Lumbar flexion is 45°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 150°. Internal and external rotation is 80°. Left shoulder flexion and abduction are 150°, IR and ER are 80°. There is mild positive impingement sign at both shoulders. Spurling's is negative. Right shoulder MP is 5/5. Left shoulder MP is grossly 5-/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 100° with end range mild pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° on the right and 115 degrees on the left. Left knee portal scars mostly healed with mild edema. There is mild crepitus in the right knee. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 20°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is mild tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 1x/ week, mostly for the post op knee. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise and may need SCS or follow up with Dr. Faloon. She will follow up with Dr. Scilaris about the left shoulder. She will follow up with me in six weeks. She will continue TENS. She will continue LSO, cervical traction and bilateral soft knee braces. She may require left shoulder injection. I referred her to Dr. Lempert for neurology evaluation.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
Brooklyn

54 South Dean Street
Englewood NJ 07631
T: 201-871-4000 F: 201-608-6938

100A Livingston Street
Brooklyn NY 11201
T: 718-852-4300 F: 718-858-4265

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: 08/02/2017

RE: Falero, Diana

FOLLOW UP REPORT

History / Chief Complaints: The patient is a 67-year-old right-handed female who sustained injury on May 4, 2015 when she was walking by Domino's Pizza truck and stacks of trays fell on her, knocking her down. She denies loss of consciousness, but does report immediate dizziness. She states she injured her head, neck and lower back, bilateral shoulders, bilateral hip, knees, ankles and feet. She also complains of twitching in the right upper lip on and off since the injury, but now not so often. She still has constant neck and back pain and stiffness. She feels the neck and back motion is very restricted. She feels her neck and back are her main problems. She feels her neck and back pain are both 8/10 on average on a pain scale. Ultrasound guided lumbar and cervical trigger point injections were helpful but temporary. She consulted with Dr. Moise who recommended epidurals. She recently had lumbar epidural and feels some benefit but has worn off. Her neck and back are a little worse the last month. She had epidurals with Dr. Moise and MBB. She consulted with Dr. Faloon and conservative care was decided upon. She feels more pain radiating down the left arm the last few weeks. She had lumbar RF with benefit. She had cervical epidural. She has constant pain in both shoulders and difficulty lifting overhead. The left shoulder is severe, around 8/10. The right shoulder is 2/10. She has tingling in both arms more on the left. She states she mentioned the balance issue to her internist but was not given a referral although neurology was reportedly discussed. She does not work and has been on SSI since around 2007. She has not worked since 2002. She is in constant pain and has stiffness in both hips, knees and feet. Walking is difficult. She has had pain in these areas before this accident and feels all her pains are worse. Physical therapy gives mild temporary benefit. She finds estim helpful and has the TENS now. She feels the left knee hurts more than the right. She reports bilateral severe hip pain. She consulted with Dr. Scilaris who initially recommended being treated with Dr. Moise first. She presently takes Mobic, Robaxin, Lidoderm, Morphine 60mg tid and Zoloft 100mg prescribed by her internists. She states several years ago she also saw a psychiatrist but not in a few years. She cannot sleep on the left shoulder. She had bilateral shoulder bursae injections with mild benefit for 1-2 weeks. Dr. Scilaris recommended surgery to the left knee- she had the surgery on 11/29/16 and attended post op physical therapy. She feels only mild pain in the knee since the surgery. She feels the left and right ankle and feet are mild and not often. The right knee pain is 3 / 10. Left knee pain is 3-5 / 10. She underwent right knee surgery on 3/16/17. She had follow-up with Dr. Scilaris and is in physical therapy. She feels the right knee is already improving nicely and the pain is 2/10. Bilateral hip pain is mild now.

Imaging/Studies: Cervical MRI revealed four level disc herniations –see report. Lumbar MRI revealed three level disc herniations, a prior lumbar MRI of 2013 did not reveal any disc injuries. EMG revealed cervical and lumbar radiculopathy. Left knee MRI revealed medial femoral condyle contusion, and medial meniscus flap tear. Right shoulder MRI revealed partial rotator cuff tear, and anterior dislocation of biceps tendon –see report, left hip MRI revealed partial gluteus medius tear, labrum tear, degenerative changes – see report. Right hip MRI revealed degenerative changes and possible labrum tear –see report. Left shoulder MRI revealed rotator cuff tear, SLAP tear, biceps tear, ac hypertrophy, bone contusion –see report. Right knee MRI revealed femoral condyle compression fracture, bone contusion, medial meniscal tear, partial ACL tear, gastrocnemius tear –see report. Left foot MRI revealed post op changes, OA of the first toe, hammer toes, neuroma-see report.

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

Date: August 2, 2017
RE: Falero, Diana

Physical Exam: She is using a cane and ambulates a little slowly. There is cervical and lumbar spasm and tenderness bilaterally. There is bilateral upper trapezius spasm and tenderness. Cervical flexion and extension is 20°, left and right side bending is 20°. Left and right rotation is 60°. Lumbar flexion is 45°, extension is 10°, left and right side bending is 20°. There is diffuse tenderness of both shoulders anteriorly and posteriorly. Right shoulder flexion and abduction are 150°. Internal and external rotation is 80°. Left shoulder flexion and abduction are 150°, IR and ER are 80°. There is mild positive impingement sign at both shoulders. Right shoulder MP is 5/5. Left shoulder MP is grossly 5-/5. Elbow and wrist range of motion are grossly normal. There is tenderness of both hips anteriorly and laterally. Bilateral hip flexion is 100° with end range mild pain and internal rotation is10° with pain. There is full extension of both knees and flexion is 115° on the right and 115 degrees on the left. Left knee portal scars healed with mild edema. There is mild crepitus in the right knee. There is mild edema at both ankles laterally with mild tenderness. Bilateral ankle dorsiflexion is 20°, plantar flexion is 35°, inversion is 10°, and eversion is 5°. There is mild tenderness on the dorsum of both feet. There is tenderness over the left foot medial arch.

Assessment/Plan: She will attend physical therapy 1x/ week. I will not prescribe any medications as she already takes several. She will follow up with Dr. Moise and may need SCS and follow up with Dr. Faloon. She will follow up with Dr. Scilaris about the left shoulder. She will follow up with me in six weeks. She will continue TENS. She will continue LSO, cervical traction and bilateral soft knee braces. She may require left shoulder injection-she is considering. I referred her to Dr. Lempert for neurology evaluation.

Sincerely,

Charles A. Kaplan, M.D.

CK:ea
Brooklyn

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DR. KAPLAN'S NERVE CONDUCTION VELOCITY AND ELECTROMYOGRAPHY TESTING

NEW YORK
ORTHOPAEDIC SURGERY
& REHABILITATION

Christopher Kyriakides, D.O.
F.A.A., PM&R
Board Certified, ABPMR

David R. Adin, D.O.
Fellow,Royal College of Surgeons
Diplomate,American Board of Minimally Invasive Spinal Medicine & Surgery
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Thomas Scilaris, M.D.
Orthopaedic Surgery
Board Certified , ABOS

Charles A. Kaplan, M.D.
F.A.A., PM&R
Board Certified, ABPMR

Test Date: 9/1/2015

Patient:	Diana Falero	**DOB:**	2/8/1950	**Physician:**	Dr. Charles A.Kaplan
Sex:	Female	**Height:**		**Ref Phys:**	
ID#:	2325410	**Weight:**		**Technician:**	Yoshiki Takeyama

Nerve Conduction Studies

Motor Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Median Motor (Abd Poll Brev)											
Wrist		2.5	<4.0	6.5	>5	Elbow	Wrist	4.4	25.0	57	>50
Elbow		6.9		4.5							
Right Median Motor (Abd Poll Brev)											
Wrist		3.1	<4.0	8.3	>5	Elbow	Wrist	4.1	26.0	63	>50
Elbow		7.2		6.7							
Left Ulnar Seg Motor (Abd Dig Minimi)											
Wrist		2.3	<4.0	8.5	>5	B Elbow	Wrist	3.3	20.5	62	>50
B Elbow		5.6		8.9		A Elbow	B Elbow	1.9	11.0	58	
A Elbow		7.5		8.6							
Right Ulnar Seg Motor (Abd Dig Minimi)											
Wrist		2.2	<4.0	7.7	>5	B Elbow	Wrist	3.4	22.0	65	>50
B Elbow		5.6		8.4		A Elbow	B Elbow	1.7	10.5	62	
A Elbow		7.3		7.9							

Sensory Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (µV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Median D3 Sensory (3rd Digit)											
Wrist		3.0	<3.6	29.9	>15	Wrist	3rd Digit	3.0	14.0	47	>47
Palm		1.3		46.5		Palm	3rd Digit	1.3	7.0	54	
						Wrist	Palm	1.7	7.0	41	
Right Median D3 Sensory (3rd Digit)											
Wrist		3.1	<3.6	17.5	>15	Wrist	3rd Digit	3.1	14.5	47	>47
Palm		1.3		21.9		Palm	3rd Digit	1.3	7.0	54	
						Wrist	Palm	1.8	7.5	42	
Left Radial Sensory (Base 1st Digit)											
Wrist		1.5	<3.5	46.0	>15	Wrist	Base 1st Digit	1.5	8.5	57	>50
Right Radial Sensory (Base 1st Digit)											
Wrist		1.1	<3.5	36.6	>15	Wrist	Base 1st Digit	1.1	7.0	64	>50
Left Ulnar Sensory (5th Digit)											
Wrist		2.1	<3.6	34.0	>15.0	Wrist	5th Digit	2.1	12.0	57	>50
Right Ulnar Sensory (5th Digit)											
Wrist		2.2	<3.6	16.4	>15.0	Wrist	5th Digit	2.2	12.0	55	>50

F Wave Studies

NR	F-Lat (ms)	Lat Norm (ms)	L-R F-Lat (ms)	L-R Lat Norm
Left Median (Mrkrs) (Abd Poll Brev)				
	25.36	<33	0.00	<3
Right Median (Mrkrs) (Abd Poll Brev)				
	25.36	<33	0.00	<3
Left Ulnar (Mrkrs) (Abd Dig Min)				
	25.46	<36	0.00	<3
Right Ulnar (Mrkrs) (Abd Dig Min)				
	25.46	<36	0.00	<3

EMG

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Right	Deltoid	Axillary	C5-6	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Right	Biceps	Musculocut	C5-6	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Right	Triceps	Radial	C6-7-8	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Right	FlexCarRad	Median	C6-7	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Right	1stDorInt	Ulnar	C8-T1	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	Deltoid	Axillary	C5-6	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	Biceps	Musculocut	C5-6	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	Triceps	Radial	C6-7-8	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	FlexCarRad	Median	C6-7	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	1stDorInt	Ulnar	C8-T1	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	ExtDigCom	Radial (Post Int)	C7-8	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Right	ExtDigCom	Radial (Post Int)	C7-8	Nml	0	0	Nml	Nml	Nml	Nml	Complete	

Paraspinal EMG

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Comment
Right	C3-4 Parasp	Rami	C3-4	Nml	0	0	
Right	C4-5 Parasp	Rami	C4-5	Nml	0	0	
Right	C5-6 Parasp	Rami	C5-6	Nml	0	0	
Right	C6-7 Parasp	Rami	C6-7	Nml	0	0	
Right	C7-T1 Parasp	Rami	C7-T1	Nml	0	0	
Left	C3-4 Parasp	Rami	C3-4	Nml	0	0	
Left	C4-5 Parasp	Rami	C4-5	Nml	0	0	
Left	C5-6 Parasp	Rami	C5-6	Nml	1+	0	
Left	C6-7 Parasp	Rami	C6-7	Nml	1+	0	
Left	C7-T1 Parasp	Rami	C7-T1	Nml	0	0	

FINDINGS:

Evaluation of the Left Median Motor, the Right Median Motor, the Left Ulnar Seg Motor, the Right Ulnar Seg Motor, the Left Median D3 Sensory, the Right Median D3 Sensory, the Left Radial Sensory, the Right Radial Sensory, the Left Ulnar Sensory, and the Right Ulnar Sensory nerves were unremarkable.

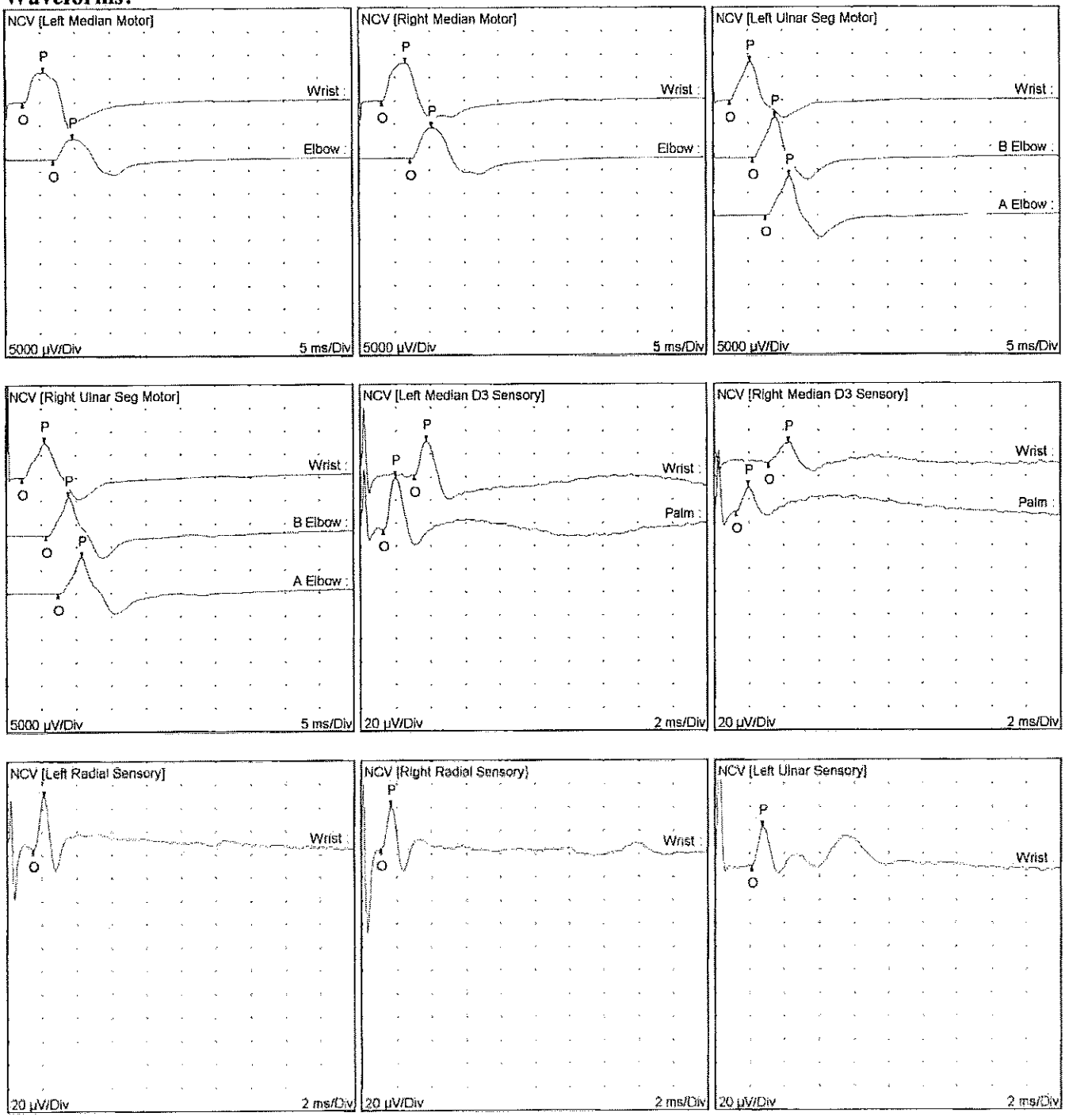
All F Wave latencies were within normal limits. All F Wave left vs. right side latency differences were within normal limits.

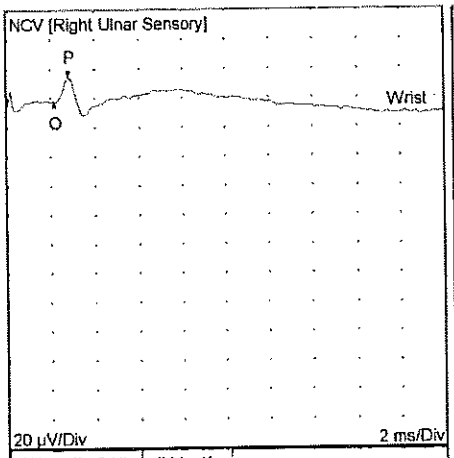
EMG needle evaluation of the Left C5-6 Parasp and the Left C6-7 Parasp showed slightly increased spontaneous activity. All remaining muscles (as indicated in the EMG scoring table) showed no evidence of electrical instability.

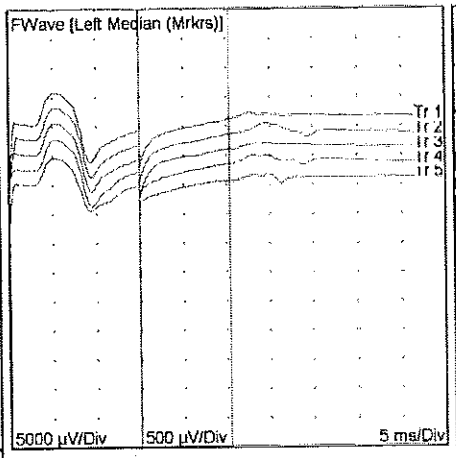
IMPRESSIONS:
The above electrodiagnostic study reveals evidence of left cervical radiculopathy.

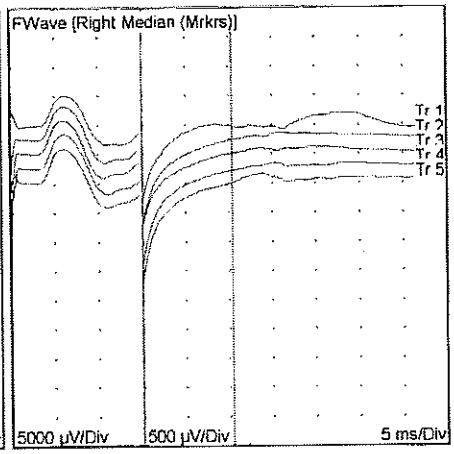
Charles A. Kaplan, M.D.
Board Certified Physical Medicine & Rehabilitation.

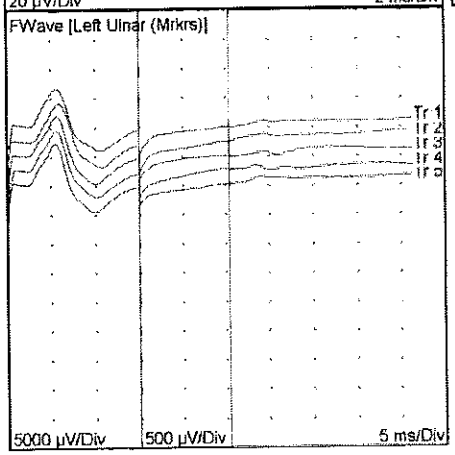
Waveforms:

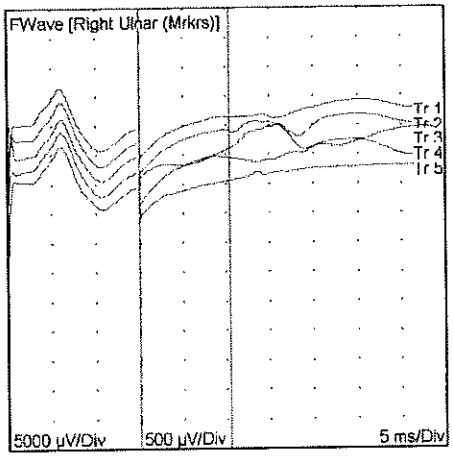

NCV [Left Median Motor]
Wrist
Elbow
5000 µV/Div
5 ms/Div
NCV [Right Median Motor]
Wrist
Elbow
5000 µV/Div
5 ms/Div
NCV [Left Ulnar Seg Motor]
Wrist
B Elbow
A Elbow
5000 µV/Div
5 ms/Div
NCV [Right Ulnar Seg Motor]
Wrist
B Elbow
A Elbow
5000 µV/Div
5 ms/Div
NCV [Left Median D3 Sensory]
Wrist
Palm
20 µV/Div
2 ms/Div
NCV [Right Median D3 Sensory]
Wrist
Palm
20 µV/Div
2 ms/Div
NCV [Left Radial Sensory]
Wrist
20 µV/Div
2 ms/Div
NCV [Right Radial Sensory]
Wrist
20 µV/Div
2 ms/Div
NCV [Left Ulnar Sensory]
Wrist
20 µV/Div
2 ms/Div


NCV [Right Ulnar Sensory]
P
O
Wrist
20 µV/Div
2 ms/Div


FWave [Left Median (Mrkrs)]
Tr 1
Tr 2
Tr 3
Tr 4
Tr 5
5000 µV/Div
500 µV/Div
5 ms/Div


FWave [Right Median (Mrkrs)]
Tr 1
Tr 2
Tr 3
Tr 4
Tr 5
5000 µV/Div
500 µV/Div
5 ms/Div


FWave [Left Ulnar (Mrkrs)]
Tr 1
Tr 2
Tr 3
Tr 4
Tr 5
5000 µV/Div
500 µV/Div
5 ms/Div


FWave [Right Ulnar (Mrkrs)]
Tr 1
Tr 2
Tr 3
Tr 4
Tr 5
5000 µV/Div
500 µV/Div
5 ms/Div

NEW YORK
ORTHOPAEDIC SURGERY
& REHABILITATION

Christopher Kyriakides, D.O.
F.A.A., PM&R
Board Certified, ABPMR

David R. Adin, D.O.
Fellow,Royal College of Surgeons
Diplomate,American Board of Minimally Invasive Spinal Medicine & Surgery
Board Certified, ABPMR

Thomas Scilaris, M.D.
Orthopaedic Surgery
Board Certified , ABOS

Charles A. Kaplan, M.D.
F.A.A., PM&R
Board Certified, ABPMR

Test Date: 8/4/2015

Patient:	Diana Falero	**DOB:**	2/8/1950	**Physician:**	Dr. Charles A.Kaplan
Sex:	Female	**Height:**		**Ref Phys:**	
ID#:	2325410	**Weight:**		**Technician:**	Yoshiki Takeyama

Nerve Conduction Studies

Motor Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Peroneal Motor (Ext Dig Brev)											
Ankle		5.5	<7.0	0.4	>2	B Fib	Ankle	5.8	29.5	51	>40
B Fib		11.3		0.3		Poplt	B Fib	1.5	7.0	47	
Poplt		12.8		0.3							
Right Peroneal Motor (Ext Dig Brev)											
Ankle		5.0	<7.0	2.9	>2	B Fib	Ankle	5.5	28.0	51	>40
B Fib		10.5		2.3		Poplt	B Fib	1.7	8.0	47	
Poplt		12.2		2.1							
Left Tibial Motor (Abd Hall Brev)											
Ankle		3.8	<7.0	4.1	>2	Poplit	Ankle	7.5	38.0	51	>40
Poplit		11.3		4.0							
Right Tibial Motor (Abd Hall Brev)											
Ankle		4.5	<7.0	2.2	>2	Poplit	Ankle	8.6	38.0	44	>40
Poplit		13.1		1.7							

Sensory Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (µV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Sural Sensory (Lat Mall)											
Calf		2.1	<3.6	10.6	>15.0	Calf	Lat Mall	2.1	0.0		>40
Right Sural Sensory (Lat Mall)											
Calf		2.2	<3.6	16.6	>15.0	Calf	Lat Mall	2.2	0.0		>40

F Wave Studies

NR	F-Lat (ms)	Lat Norm (ms)	L-R F-Lat (ms)	L-R Lat Norm
Left Tibial (Mrkrs) (Abd Hallucis)				
	41.47	<61	5.67	<6
Right Tibial (Mrkrs) (Abd Hallucis)				
	47.14	<61	5.67	<6

H Reflex Studies

NR	H-Lat (ms)	L-R H-Lat (ms)	L-R Lat Norm
Left Tibial (Gastroc)	30.36	0.00	<1.5
Right Tibial (Gastroc)	30.36	0.00	<1.5

EMG

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Right	AntTibialis	Dp Br Peron	L4-5	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Right	MedGastroc	Tibial	S1-2	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Right	VastusMed	Femoral	L2-4	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Right	Peroneus Long	Sup Br Peron	L5-S1	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	AntTibialis	Dp Br Peron	L4-5	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	MedGastroc	Tibial	S1-2	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	VastusMed	Femoral	L2-4	Nml	0	0	Nml	Nml	Nml	Nml	Complete	
Left	Peroneus Long	Sup Br Peron	L5-S1	Nml	0	0	Nml	Nml	Nml	Nml	Complete	

Paraspinal EMG

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Comment
Right	L1-2 Parasp	Rami	L1-2	Nml	0	0	
Right	L2-3 Parasp	Rami	L2-3	Nml	0	0	
Right	L3-4 Parasp	Rami	L3-4	Nml	0	0	
Right	L4-5 Parasp	Rami	L4-5	Nml	1+	0	
Right	L5-S1Parasp	Rami	L5-S1	Nml	0	0	
Left	L1-2 Parasp	Rami	L1-2	Nml	0	0	
Left	L2-3 Parasp	Rami	L2-3	Nml	0	0	
Left	L3-4 Parasp	Rami	L3-4	Nml	0	0	
Left	L4-5 Parasp	Rami	L4-5	Nml	0	0	
Left	L5-S1Parasp	Rami	L5-S1	Nml	1+	0	

FINDINGS:

Evaluation of the Left Peroneal Motor and the Left Sural Sensory nerves showed reduced amplitude (L0.4, L10.6 uV). The Right Peroneal Motor, the Left Tibial Motor, the Right Tibial Motor, and the Right Sural Sensory nerves were unremarkable.

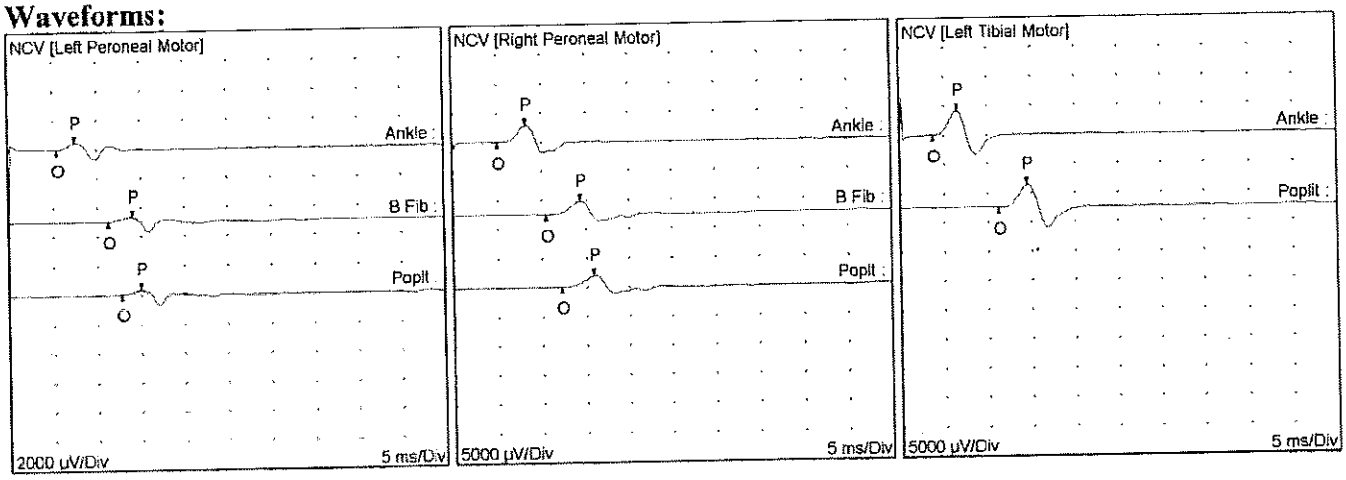
All F Wave latencies were within normal limits. All F Wave left vs. right side latency differences were within normal limits. All H Reflex left vs. right side latency differences were within normal limits.

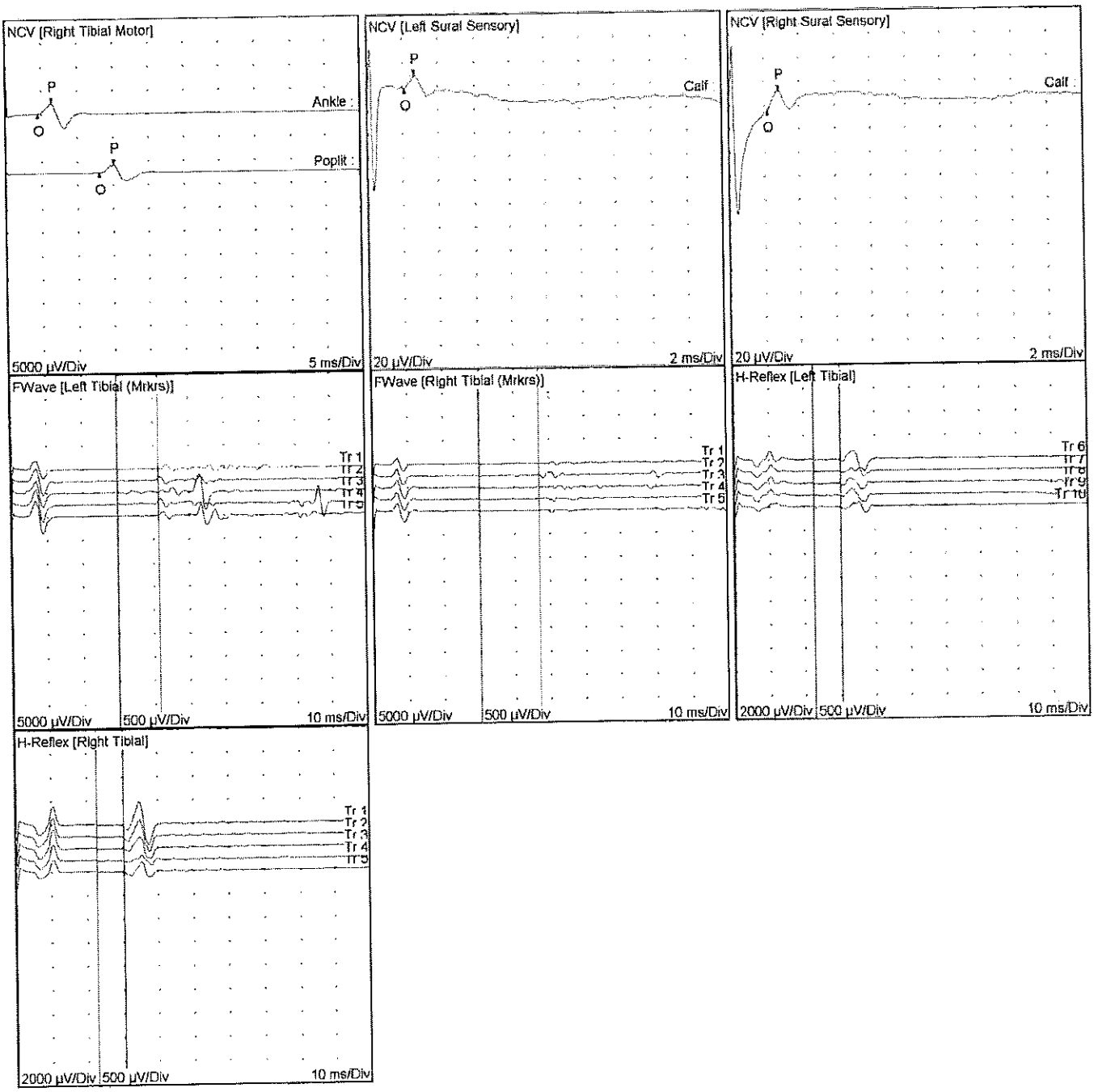
EMG needle evaluation of the Right L4-5 Parasp and the Left L5-S1Parasp showed slightly increased spontaneous activity. All remaining muscles (as indicated in the EMG scoring table) showed no evidence of electrical instability.

IMPRESSIONS:
The above electrodiagnostic study reveals evidence of bilateral lumbar radiculopathy. The above electrodiagnostic study also reveals evidence of mild left peroneal motor neuropathy and mild left sural sensory neuropathy.

Charles A. Kaplan, M.D.
Board Certified Physical Medicine & Rehabilitation.

Waveforms:


NCV [Left Peroneal Motor]
Ankle
B Fib
Popit
2000 µV/Div
5 ms/Div
NCV [Right Peroneal Motor]
Ankle
B Fib
Popit
5000 µV/Div
5 ms/Div
NCV [Left Tibial Motor]
Ankle
Popit
5000 µV/Div
5 ms/Div


NCV [Right Tibial Motor]
P
O
Ankle
P
O
Poplit
5000 µV/Div
5 ms/Div
NCV [Left Sural Sensory]
P
O
Calf
20 µV/Div
2 ms/Div
NCV [Right Sural Sensory]
P
O
Calf
20 µV/Div
2 ms/Div
FWave [Left Tibial (Mrkrs)]
Tr 1
Tr 2
Tr 3
Tr 4
Tr 5
5000 µV/Div
500 µV/Div
10 ms/Div
FWave [Right Tibial (Mrkrs)]
Tr 1
Tr 2
Tr 3
Tr 4
Tr 5
5000 µV/Div
500 µV/Div
10 ms/Div
H-Reflex [Left Tibial]
Tr 6
Tr 7
Tr 8
Tr 9
Tr 10
2000 µV/Div
500 µV/Div
10 ms/Div
H-Reflex [Right Tibial]
Tr 1
Tr 2
Tr 3
Tr 4
Tr 5
2000 µV/Div
500 µV/Div
10 ms/Div

DIANA FALERO
NF

C/T/L/S, B SHO, B KNEES
5/18/2015

Cervical ROM - Inclinometry

Cervical	Norm	1	2	3	4	5	6	Max	Avg	CV	Dev	Valid	Anky
Flexion	50°	20°	20°	20°	–	–	–	20°	20°	–	0°	Yes	–
Extension	60°	10°	10°	10°	–	–	–	10°	10°	–	0°	Yes	–
Lateral Left	45°	3°	3°	3°	–	–	–	3°	3°	–	0°	Yes	–
Lateral Right	45°	4°	5°	5°	–	–	–	5°	5°	–	1°	Yes	–
Rotation Left	80°	13°	12°	12°	–	–	–	13°	12°	–	1°	Yes	–
Rotation Right	80°	15°	15°	15°	–	–	–	15°	15°	–	0°	Yes	–

Thoracic ROM - Inclinometry

Thoracic	Norm	1	2	3	4	5	6	Max	Avg	CV	Dev	Valid	Anky
Minimum Kyphosis	–	7°	8°	6°	–	–	–	8°	7°	–	1°	Yes	–
Flexion	45°	3°	3°	3°	–	–	–	3°	3°	–	0°	Yes	–
Lateral Left	45°	4°	4°	4°	–	–	–	4°	4°	–	0°	Yes	–
Lateral Right	45°	6°	6°	6°	–	–	–	6°	6°	–	0°	Yes	–
Rotation Left	30°	9°	8°	9°	–	–	–	9°	9°	–	1°	Yes	–
Rotation Right	30°	5°	5°	6°	–	–	–	6°	5°	–	1°	Yes	–

Lumbar ROM - Inclinometry

Lumbar	Norm	1	2	3	4	5	6	Max	Avg	CV	Dev	Valid	Anky
Lateral Left	25°	3°	3°	3°	–	–	–	3°	3°	–	0°	Yes	–
Lateral Right	25°	3°	3°	2°	–	–	–	3°	3°	–	1°	Yes	–
Rotation Left	–	2°	2°	2°	–	–	–	2°	2°	–	0°	Yes	–
Rotation Right	–	2°	2°	2°	–	–	–	2°	2°	–	0°	Yes	–
Flexion	60°	11°	11°	10°	–	–	–	11°	11°	–	1°	Yes	–
Extension	25°	2°	2°	2°	–	–	–	2°	2°	–	0°	Yes	–
Sacral Hip Flexion	45°	0°	0°	0°	–	–	–	0°	0°	–	–	–	–
Sacral Hip Extension	–	0°	0°	0°	–	–	–	0°	0°	–	–	–	–

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C/T/L/S, B SHO, B KNEES
5/18/2015

Upper Extremity ROM - Inclinometry

A = Active
P = Passive

		Norm	Left Max	Left %N	Left 1	Left 2	Left 3	Left CV	Right Max	Right %N	Right 1	Right 2	Right 3	Right CV
Shoulder Flexion	A	180°	96°	53%	96°	96°	–	0%	65°	36%	64°	65°	–	0%
	P													
Shoulder Extension	A	50°	11°	22%	11°	11°	–	0%	8°	16%	8°	8°	–	0%
	P													
Shoulder Abduction	A	180°	90°	50%	90°	90°	–	0%	65°	36%	65°	65°	–	0%
	P													
Shoulder Adduction	A	50°	28°	56%	28°	28°	–	0%	21°	42%	21°	20°	–	2%
	P													
Shoulder Internal Rotation	A	90°	10°	11%	10°	10°	–	0%	9°	10%	9°	9°	–	0%
	P													
Shoulder External Rotation	A	90°	44°	49%	44°	44°	–	0%	40°	44%	39°	40°	–	1%
	P													
Elbow Flexion	A													
	P													
Elbow Extension	A													
	P													
Elbow Pronation	A													
	P													
Elbow Supination	A													
	P													
Wrist Flexion	A													
	P													
Wrist Extension	A													
	P													
Wrist Radial Deviation	A													
	P													
Wrist Ulnar Deviation	A													
	P													

DIANA FALERO
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C/T/L/S, B SHO, B KNEES
5/18/2015

Lower Extremity ROM - Inclinometry

A = Active
P = Passive

		Norm	Left Max	Left %N	Left 1	Left 2	Left 3	Left CV	Right Max	Right %N	Right 1	Right 2	Right 3	Right CV
Hip Flexion	A													
	P													
Hip Extension	A													
	P													
Hip Abduction	A													
	P													
Hip Adduction	A													
	P													
Hip Internal Rotation	A													
	P													
Hip External Rotation	A													
	P													
Knee Flexion	A	150°	90°	60%	90°	90°	–	0%	82°	55%	82°	82°	–	0%
	P													
Knee Extension	A	0°	0°	–	0°	0°	–	0%	0°	–	0°	0°	–	0%
	P													
Ankle Plantar Flexion	A													
	P													
Ankle Dorsiflexion	A													
	P													
Foot Inversion	A													
	P													
Foot Eversion	A													
	P													
Hindfoot Inversion	A													
	P													
Hindfoot Eversion	A													
	P													

Cervical Range of Motion (ROM) Details

Motion		1	2	3	4	5	6	Max	Valid
Flexion	Primary	20°	20°	20°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Flexion Angle	20°	20°	20°	–	–	–	20°	Yes
Extension	Primary	10°	10°	10°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Extension Angle	10°	10°	10°	–	–	–	10°	Yes
Lateral Left	Primary	3°	3°	3°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Lateral Left Angle	3°	3°	3°	–	–	–	3°	Yes
Lateral Right	Primary	4°	5°	5°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Lateral Right Angle	4°	5°	5°	–	–	–	5°	Yes
Rotation Left	Rotation Left Angle	13°	12°	12°	–	–	–	13°	Yes
Rotation Right	Rotation Right Angle	15°	15°	15°	–	–	–	15°	Yes

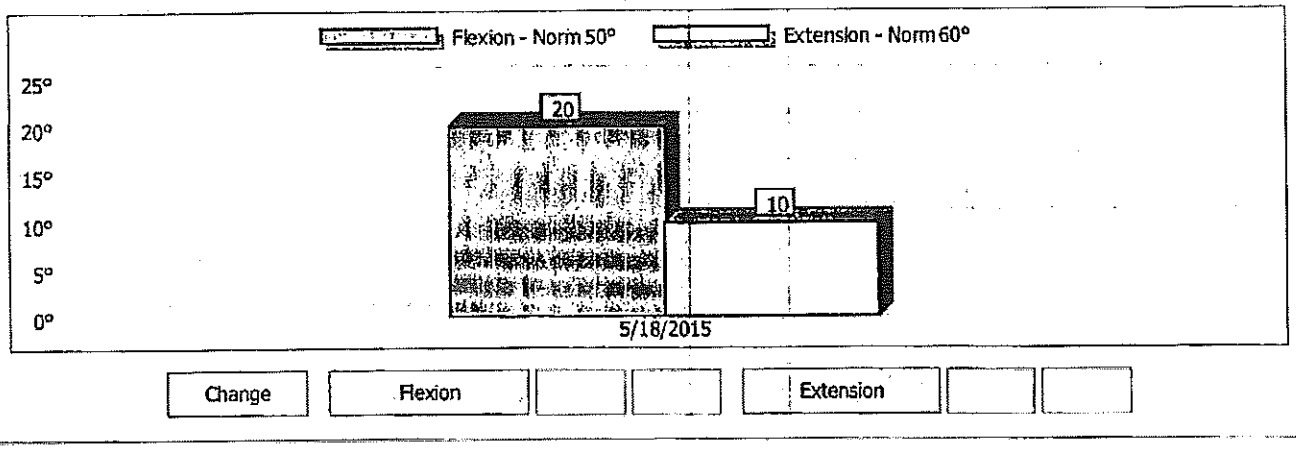
Thoracic Range of Motion (ROM) Details

Motion		1	2	3	4	5	6	Max	Valid
Minimum Kyphosis	Primary	7°	8°	6°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Minimum Kyphosis Angle	7°	8°	6°	–	–	–	8°	Yes
Flexion	Primary	3°	3°	3°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Flexion Angle	3°	3°	3°	–	–	–	3°	Yes
Lateral Left	Primary	4°	4°	4°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Lateral Left Angle	4°	4°	4°	–	–	–	4°	Yes
Lateral Right	Primary	6°	6°	6°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Lateral Right Angle	6°	6°	6°	–	–	–	6°	Yes
Rotation Left	Primary	9°	8°	9°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Rotation Left Angle	9°	8°	9°	–	–	–	9°	Yes
Rotation Right	Primary	5°	5°	6°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Rotation Right Angle	5°	5°	6°	–	–	–	6°	Yes

Lumbar Range of Motion (ROM) Details

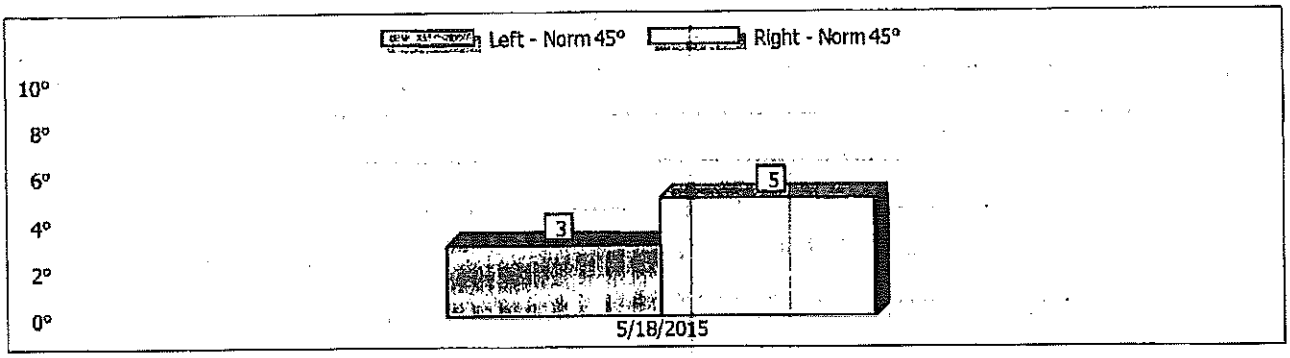
Motion		1	2	3	4	5	6	Max	Valid
Flexion	Primary	11°	11°	10°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Flexion Angle	11°	11°	10°	–	–	–	11°	Yes
Extension	Primary	2°	2°	2°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Extension Angle	2°	2°	2°	–	–	–	2°	Yes
Straight Leg Raise Left	Left SLR Angle								
Straight Leg Raise Right	Right SLR Angle								
Lateral Left	Primary	3°	3°	3°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Lateral Left Angle	3°	3°	3°	–	–	–	3°	Yes
Lateral Right	Primary	3°	3°	3°	–	–	–		
	Secondary	0°	0°	1°	–	–	–		
	Lateral Right Angle	3°	3°	2°	–	–	–	3°	Yes
Rotation Left	Primary	2°	2°	2°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Rotation Left Angle	2°	2°	2°	–	–	–	2°	Yes
Rotation Right	Primary	2°	2°	2°	–	–	–		
	Secondary	0°	0°	0°	–	–	–		
	Rotation Right Angle	2°	2°	2°	–	–	–	2°	Yes

Progress Report - ROM - Cervical Flexion/Extension



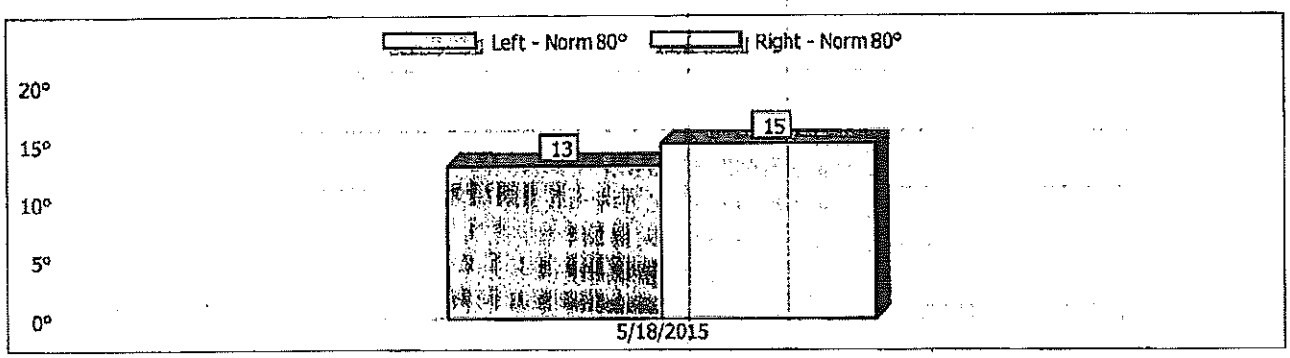
Change	Flexion			Extension		

Progress Report - ROM - Cervical Lateral Flexion



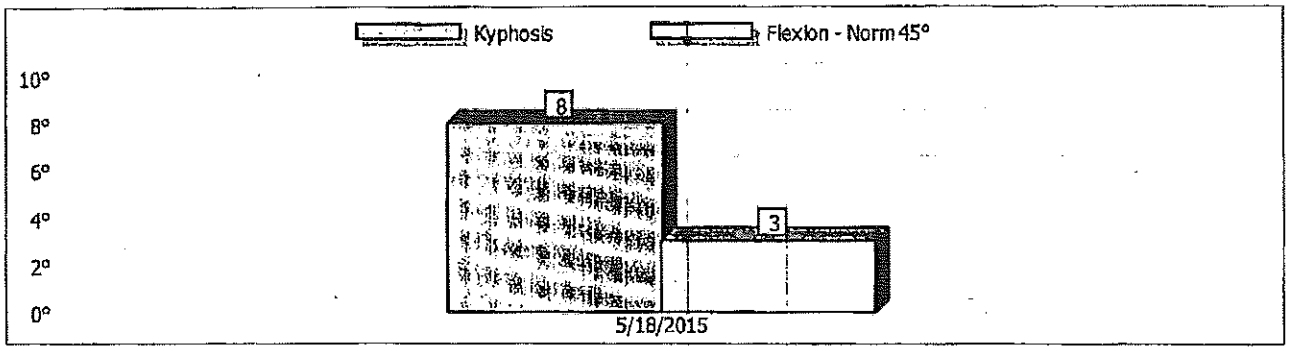
Change	Left			Right		

Progress Report - ROM - Cervical Rotation



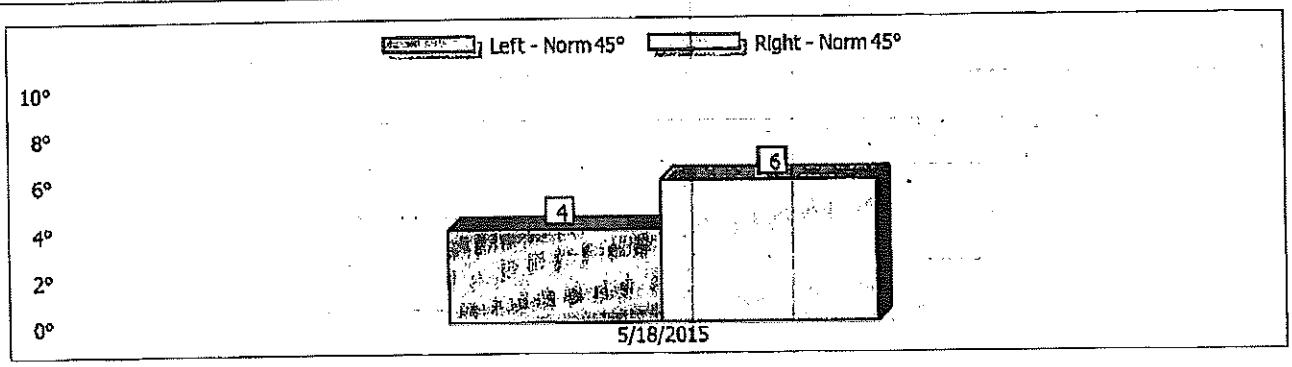
Change	Left			Right		

Progress Report - ROM - Thoracic Minimum Kyphosis/Flexion



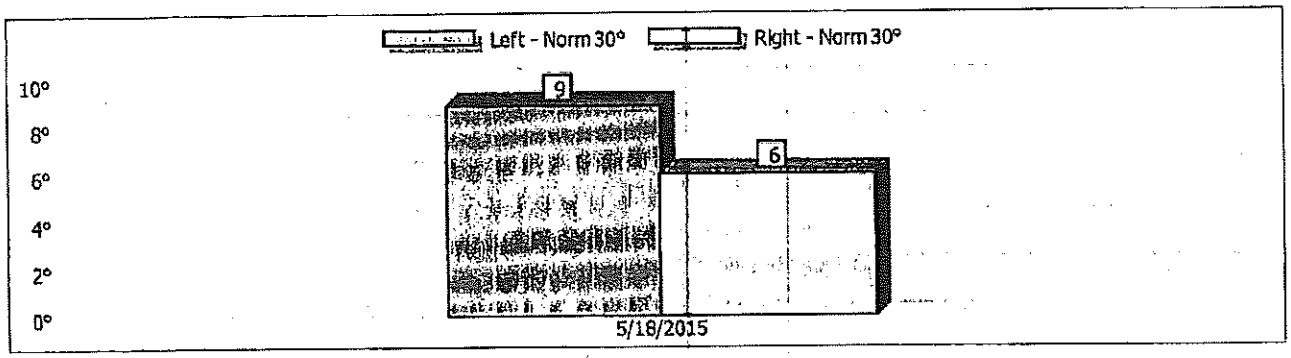
Change	Kyphosis			Flexion		

Progress Report - ROM - Thoracic Lateral Flexion



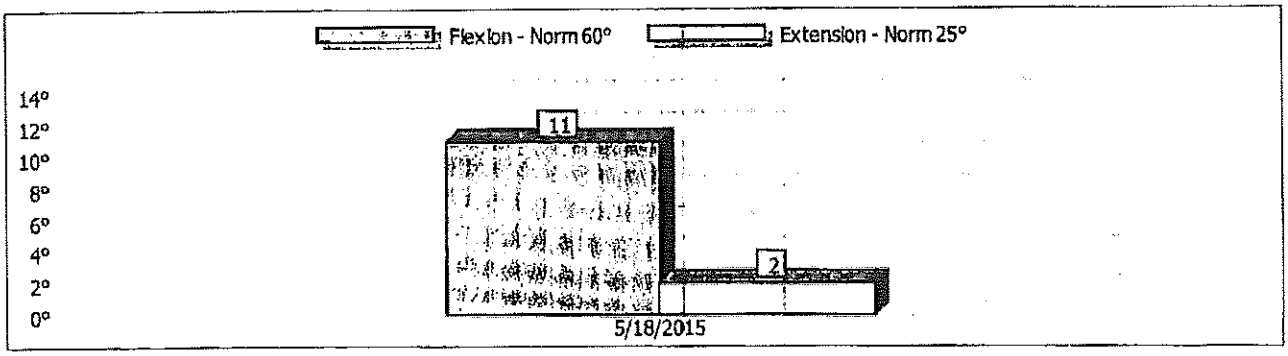
Change	Left			Right		

Progress Report - ROM - Thoracic Rotation



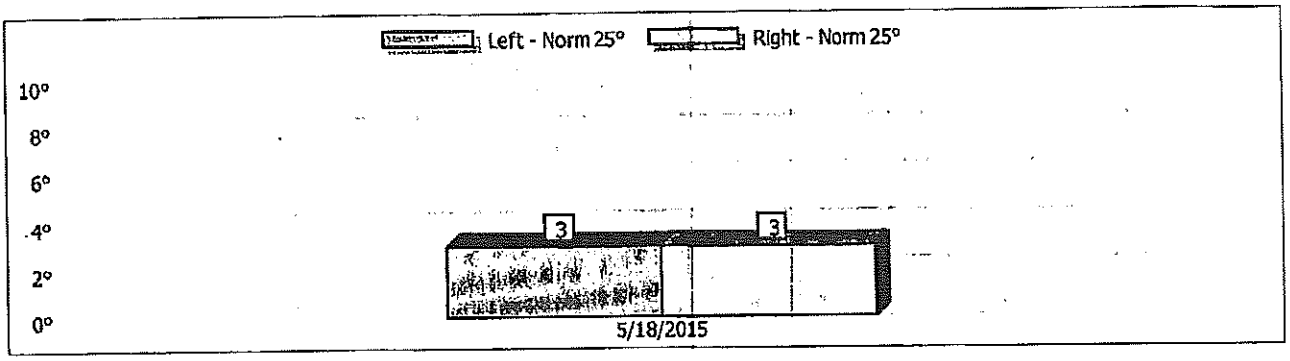
Change	Left			Right		

Progress Report - ROM - Lumbar Flexion/Extension



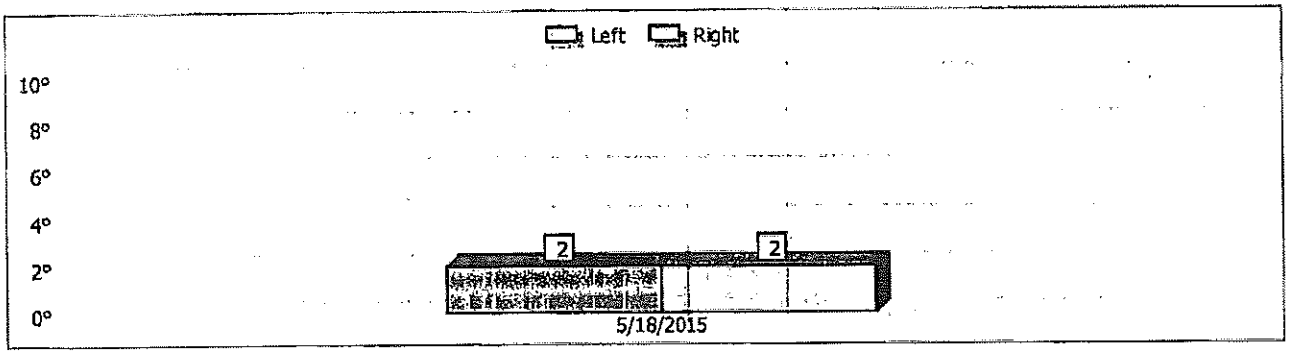
Change	Flexion			Extension		

Progress Report - ROM - Lumbar Lateral Flexion



Change	Left			Right		

Progress Report - ROM - Lumbar Rotation

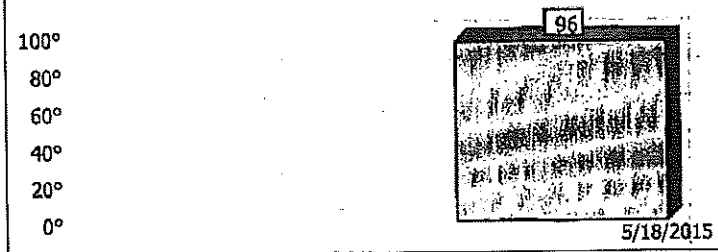


Change	Left			Right		

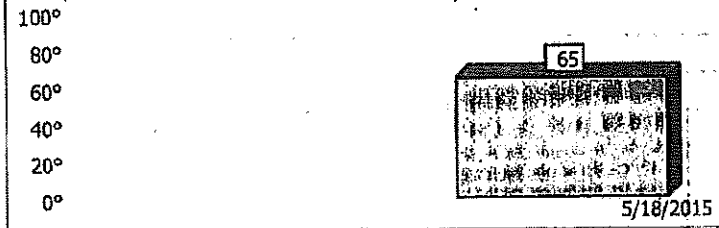
Progress Report - ROM - Shoulder Flexion/Extension

Active Passive

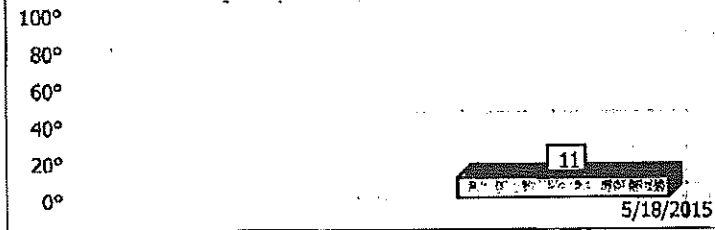
Flexion Left - Norm 180°



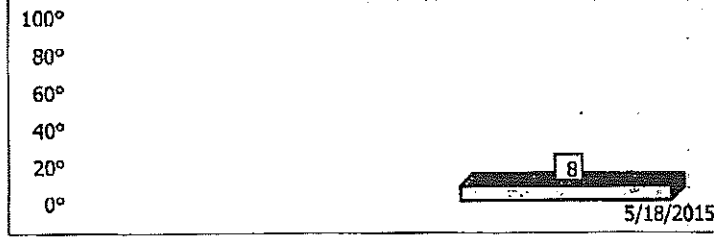
Flexion Right - Norm 180°



Extension Left - Norm 50°



Extension Right - Norm 50°

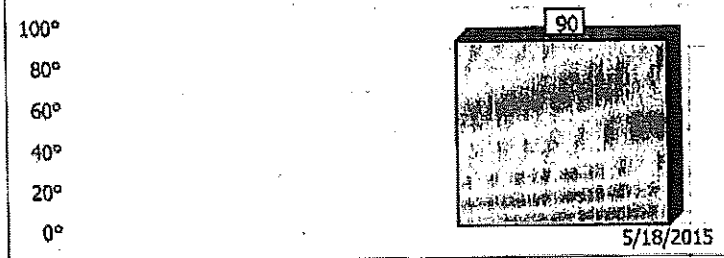


	Left				Right			
Change	Active		Passive		Active		Passive	
Flexion								
Extension								

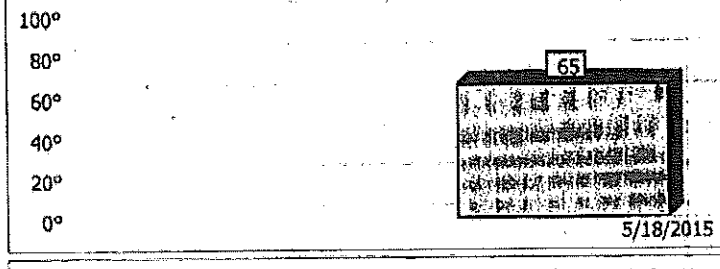
Progress Report - ROM - Shoulder Abduction/Adduction

Active Passive

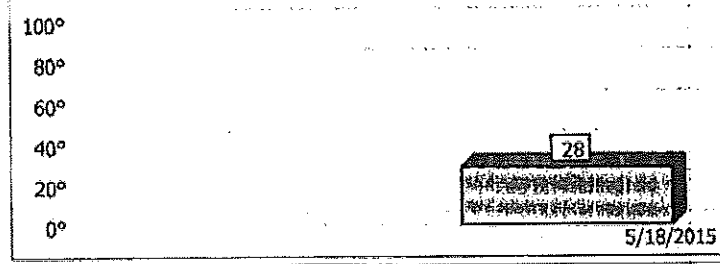
Abduction Left - Norm 180°



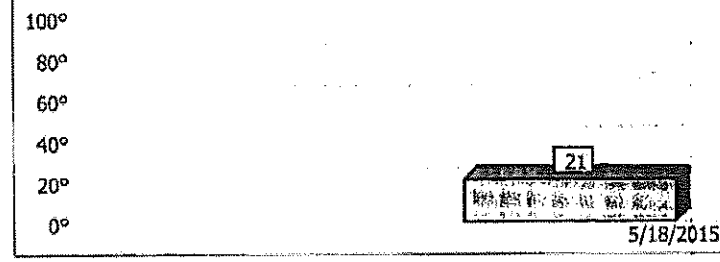
Abduction Right - Norm 180°



Adduction Left - Norm 50°



Adduction Right - Norm 50°

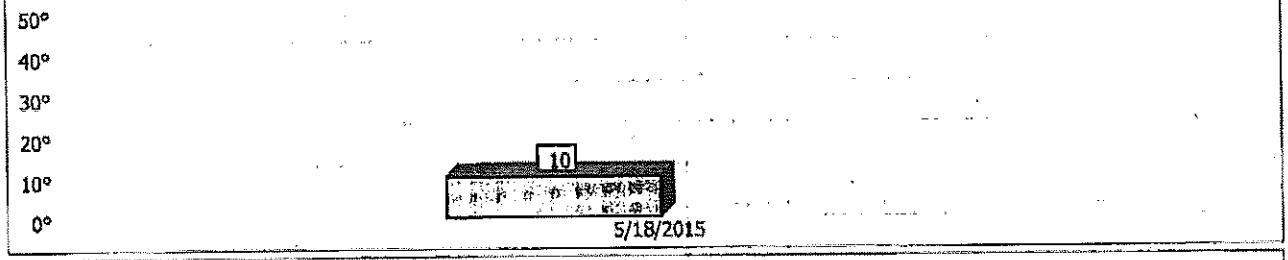


	Left				Right			
Change	Active		Passive		Active		Passive	
Abduction								
Adduction								

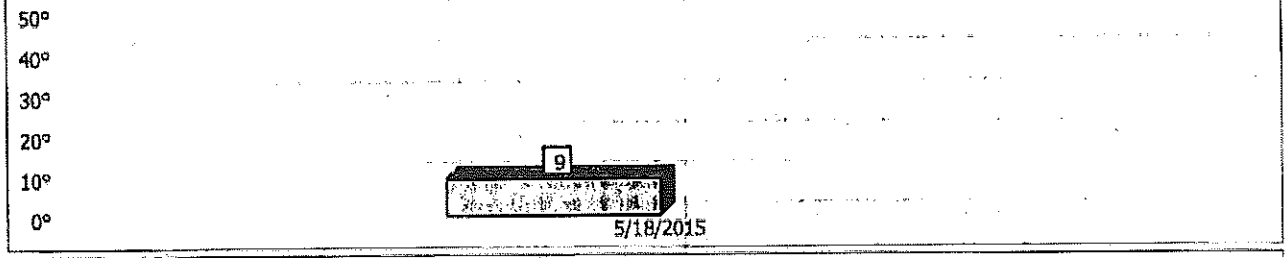
Progress Report - ROM - Shoulder Internal/External Rotation

Active Passive

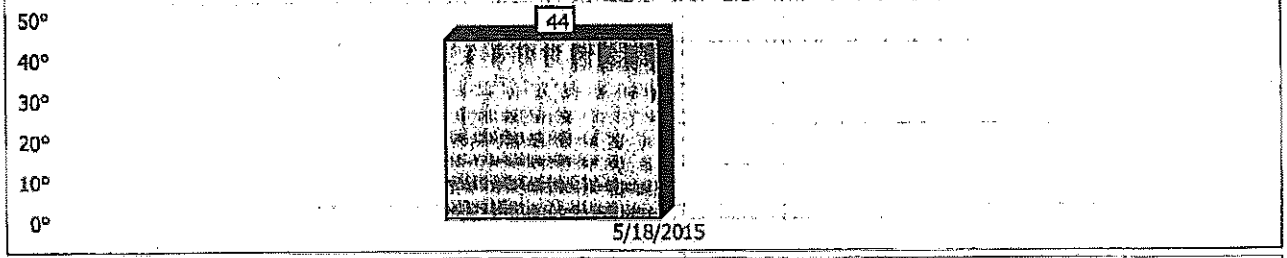
Internal Left - Norm 90°



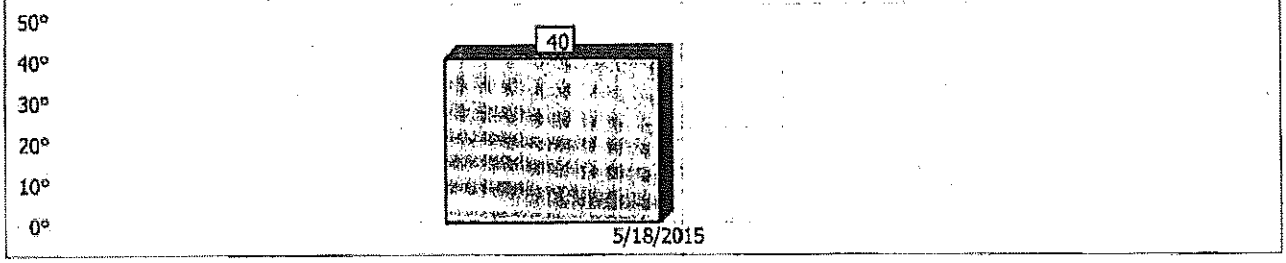
Internal Right - Norm 90°



External Left - Norm 90°



External Right - Norm 90°

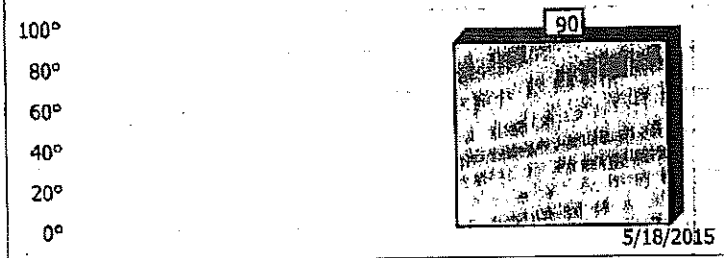


	Left				Right			
Change	Active		Passive		Active		Passive	
Internal								
External								

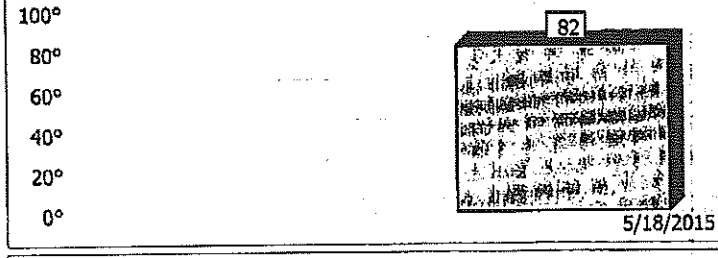
Progress Report - ROM - Knee Flexion/Extension

Active Passive

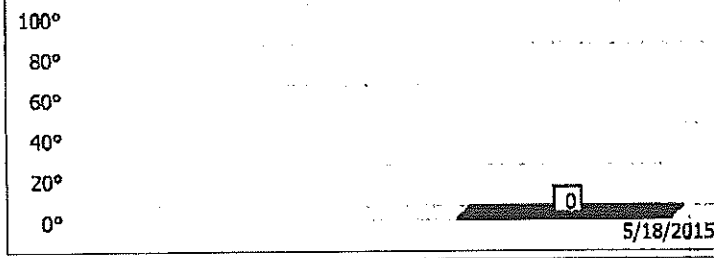
Flexion Left - Norm 150°



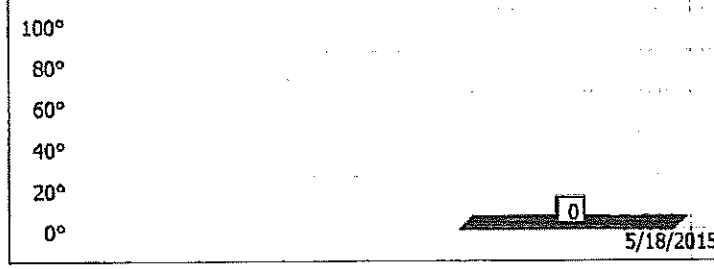
Flexion Right - Norm 150°



Extension Left - Norm 0°



Extension Right - Norm 0°



	Left				Right			
Change	Active		Passive		Active		Passive	
Flexion								
Extension								

OTHER PHYSICIANS' OFFICE AND PROCEDURE NOTES,

AND OPERATIVE REPORTS

SPINE & ORTHOPAEDIC
REHABILITATION CENTER

54 South Dean Street
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T: 201-871-4000 F: 201-608-6938

100 Livingston Street
Brooklyn, NY 11201
T: 718-852-4300 F: 718-858-4265

DOS:9/30/2015

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Initial Evaluation

This is from Spine Ortho in Brooklyn.

HPI: The patient is here for orthopedic evaluation of the right shoulder and left knee region. She is a 65-year-old female, who on May 4, 2015, walking past a Domino's truck when a stack of trays fell on her. She fell down. She has been treated with injuries to the above-mentioned body parts. She is going to see Dr. Moise for possible epidurals of the neck and low back. She is complaining of significant pain with radiation down her arm and left hip, left leg region. Moreover, she denies previous injuries to the left knee or right shoulder. The right shoulder reveals anterior dislocation of the biceps, partial-thickness supra and subscapularis rotator cuff tears. Left knee reveals a contusion of the medial femoral condyle with flap tear of posterior horn medial meniscus.

PHYSICAL EXAMINATION: Physical examination of the left knee reveals exquisite pain and tenderness along the medial joint line. McMurray testing is positive. Flexion 110 and extension 0 degrees with crepitus. The right shoulder reveals pain and tenderness along the anterolateral acromion and 165 degrees of forward flexion is noted, abduction is 120 with moderate impingement. Tenderness along the biceps noted.

DIAGNOSES:
1. Status post fall, hit by Domino's stack of trays on 05/04/2015.
2. Left knee medial meniscal tear, flap tear.
3. Right shoulder subscapularis tear with partial biceps subluxation.

TREATMENT PLAN: Options were discussed with the patient. She is scheduled to see Dr. Moise and do believe she is a candidate for epidurals certainly in the lumbar

spine, which could help address some of the knee issues ultimately. After possible epidural, she is a candidate for arthroscopy of her left knee and right shoulder.

Thomas A. Scilaris, M.D.

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Orthopaedic Consultation

Patient Name: Falero, Diana
Date of Birth:
Medical Record#: 20121
Date: 12/07/2016

HPI: Follow up of her left knee status post arthroscopy yesterday.

PHYSICAL EXAMINATION: Today, Steri-Strips were changed. No signs of infection. There was no calf tenderness. Negative Homans sign. She flexes about 80 degrees and extends out to 0. We changed her Steri-Strips. We wrapped her.

TREATMENT PLAN: I will start some therapy starting early next week and will see her back in about a month.

<997>
Thomas A. Scilaris, M.D.

ZyDoc.com job#: 676145926562137td20121
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01/04/2017

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Follow Up Evaluation

HPI: This patient is here for a followup evaluation after left knee arthroscopy on 12/06/2016. She notes that her left knee is improving. She is still complaining of right knee pain.

MRI of right knee did indicate meniscal tear chondral injury, compression fracture.

PHYSICAL EXAMINATION: Examination of right knee reveals knee orthosis removed, range-of-motion 0 to 110 posterior medial and lateral compartment. Pain with patellofemoral compression. Positive McMurray. Negative anterior drawer. No calf tenderness. Negative Homans.

Left knee range-of-motion 0 to 120, improving quadriceps girth.

IMPRESSION:
1. Status post left knee arthroscopy, improving.
2. Right knee derangement.

PLAN: I have discussed the problem at length with the patient. At this time, she wishes to proceed with right knee arthroscopy. She would like similar results as she did with the left knee. She requires medical clearance.

The pros and cons of surgical intervention were discussed at length with the patient. Anesthetic complications, including, but not limited to, death were discussed, as well as surgical complications, including, but not limited to, continued pain, stiffness, weakness, re-operation, infection, development of complex regional pain syndrome, bleeding, thrombosis, neurovascular injury and death. The patient's questions were answered sufficiently.

This document was electronically signed by Richard Cohen5 on 3/10/2017 10:04:50 AM

Richard Cohen, R.P.A. – C.
Thomas A. Scilaris, M.D.
David R. Capiola, M.D.

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Date of Dictation: 01/04/2017
Date of Transcription: 01/05/2017

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T: 718-852-4300

Orthopaedic Consultation

Patient Name: Falero, Diana
Date of Birth:
Medical Record#: 20120
Date: 03/22/2017

HPI: This patient is here for followup evaluation after recent right knee arthroscopy performed on 03/16/2017. She notes the right knee is improving. Left knee continues to improve after arthroscopy as well.

PHYSICAL EXAMINATION: Examination of right knee reveals healed wounds without infection. Range-of-motion 0 to 100. No calf tenderness. Negative Homans.

IMPRESSION:
1. Status post right knee arthroscopy from 03/16/2017.
2. Status post left knee arthroscopy on 12/06/2016.

PLAN: Postop physical therapy has been prescribed. I have discussed the operative findings with the patient, she will for reevaluation in 6 weeks.

<997>

Richard Cohen, R.P.A. – C.
Thomas A. Scilaris, M.D.
David R. Capiola, M.D.

ZyDoc.com Job#: 682154526605647td0
Date of Dictation: 03/22/2017
Date of Transcription: 03/23/2017

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100 A Livingston Street
Brooklyn, NY 11201
T: 718-852-4300

Orthopaedic Consultation

Patient Name: Falero, Diana
Date of Birth:
Medical Record#: 20120
Date: 05/03/2017

HPI: The patient is here for a follow up of her bilateral knees. She has recent arthroscopy of the right knee dated 03/16/2017. She feels much better. She still utilizes cane secondary to fell and balance issues but she feels her knee pain has improved.

PHYSICAL EXAMINATION: Examination of her right knee reveals flexion of 125 degrees and extension 0 degrees. No crepitus today. Improvement in strength. Left knee flexion 125 and 130 and extends out to 0. No tenderness per se.

TREATMENT AND PLAN: At present time, we would continue as per physiatry doctor Dr. Caplan, orthopedically. I will see her back on a p.r.n. basis.

<997>
Thomas A. Scilaris, M.D.

ZyDoc.com job#: 684214726624089td20120
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Date of Transcription: 05/04/2017

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Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.: 20121
OFFICE CHART NO.:
DATE OF SURGERY: 10/28/2016

PREOPERATIVE DIAGNOSIS: Lumbar radiculopathy.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE: Caudal Epidural Steroid Injection under fluoroscopic guidance.

SURGEON: Anson M. Moise, MD

ANESTHESIOLOGIST: Harold Delaleu, M.D.

PROCEDURE NOTE: The above noted patient has been seen and has a positive history and physical/imaging exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Patient was brought to the procedure room and placed in the prone position. Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaine and 0.25% Bupivacaine using 22G 1.5" needle. The level to be accessed was identified under fluoroscopy: sacaral hiatus. A 22 G 3 1/2 inch spinal needle advanced under fluoroscopic guidance (lateral view) into the epidural space. Intravascular and intrathecal injection was excluded. There were no parasthesias during the needle placement. After negative aspiration 2 cc of non-ionic contrast, Omnipaque 180 injected revealing epidural spread. A 20 cc mixture of 2cc of 0.25% bupivacaine, 16cc sterile NS and 80mg's (2cc) of methylprednisolone injected at the level mentioned. The needle was then withdrawn, flushed with NS and then removed.
The patient tolerated procedure well. A&Ox3, VSS, discharged in good & stable condition.

COMPLICATIONS: None.

Patient was given post-procedure instructions. The patient was instructed to return to physical therapy at the earliest possible appointment, as it is imperative to continue with the modalities while undergoing interventional treatments in order to sustain significant and long-term relief.

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Anson M. Moise, M.D.

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Date of Transcription: 10/29/2016

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Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.: 20121
OFFICE CHART NO.:
DATE OF SURGERY: 11/11/2016

PREOPERATIVE DIAGNOSIS: Cervical radiculopathy.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE: Interlaminar Cervical Epidural Steroid Injection Under fluoroscopic guidance, C7-T1.

SURGEON: Anson M. Moise, M.D.

ANESTHESIOLOGIST: Andrew Boruta, DO

The above noted patient has been seen and has a positive history, physical and imaging exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion using betadine. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaine and 0.25% Bupivacaine using 22G 1.5" needle. The level to be accessed was identified under fluoroscopy. An 18g Tuohy needle advanced under fluoroscopic guidance into the epidural space. Epidural space identified by hanging drop technique, and confirmed with lateral view. Intravascular and intrathecal injection was excluded using isovue 2cc. There were no parasthesias during the needle placement. After negative aspiration, a 6cc mixture of 2cc (12mg) of betamethasone and 4cc sterile NS injected at the level mentioned. The needle was then withdrawn, flushed with NS and then removed. The patient tolerated procedure well. A&Ox3, VSS, discharged in good & stable condition.

COMPLICATIONS: None.

Patient was given post-procedure instructions. The patient was instructed to return to physical therapy at the earliest possible appointment, as it is imperative to continue with the modalities while undergoing interventional treatments in order to sustain significant and long-term relief.

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Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.: 20121-1
OFFICE CHART NO.:
DATE OF SURGERY: 12/28/2016

PREOPERATIVE DIAGNOSIS: Lumbar radiculopathy.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE: Caudal Epidural Steroid Injection under fluoroscopic guidance.

SURGEON: Anson M. Moise, MD

ANESTHESIOLOGIST: Harold Delaleu, M.D.

PROCEDURE NOTE: The above noted patient has been seen and has a positive history and physical/imaging exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Patient was brought to the procedure room and placed in the prone position. Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaine and 0.25% Bupivacaine using 22G 1.5" needle. The level to be accessed was identified under fluoroscopy: sacaral hiatus. A 22 G 3 1/2 inch spinal needle advanced under fluoroscopic guidance (lateral view) into the epidural space. Intravascular and intrathecal injection was excluded. There were no parasthesias during the needle placement. After negative aspiration 2 cc of non-ionic contrast, Omnipaque 180 injected revealing epidural spread. A 20 cc mixture of 2cc of 0.25% bupivacaine, 16cc sterile NS and 80mg's (2cc) of methylprednisolone injected at the level mentioned. The needle was then withdrawn, flushed with NS and then removed.
The patient tolerated procedure well. A&Ox3, VSS, discharged in good & stable condition.

COMPLICATIONS: None.

Patient was given post-procedure instructions. The patient was instructed to return to physical therapy at the earliest possible appointment, as it is imperative to continue with the modalities while undergoing interventional treatments in order to sustain significant and long-term relief.

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Date of Transcription: 12/29/2016

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ENGLEWOOD, NJ 07631
Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.:
OFFICE CHART NO.:
DATE OF SURGERY: 01/16/2017

PREOPERATIVE DIAGNOSIS: Cervical radiculopathy.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE: Interlaminar Cervical Epidural Steroid Injection Under fluoroscopic guidance, C7-T1.

SURGEON: Anson M. Moise, M.D.

ANESTHESIOLOGIST: Dr. Delaleu.

The above noted patient has been seen and has a positive history, physical and imaging exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion using betadine. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaine and 0.25% Bupivacaine using 22G 1.5" needle. The level to be accessed was identified under fluoroscopy. An 18g Tuohy needle advanced under fluoroscopic guidance into the epidural space. Epidural space identified by hanging drop technique, and confirmed with lateral view. Intravascular and intrathecal injection was excluded using isovue 2cc. There were no parasthesias during the needle placement. After negative aspiration, a 6cc mixture of 2cc (12mg) of betamethasone and 4cc sterile NS injected at the level mentioned. The needle was then withdrawn, flushed with NS and then removed. The patient tolerated procedure well. A&Ox3, VSS, discharged in good & stable condition.

COMPLICATIONS: None.

Patient was given post-procedure instructions. The patient was instructed to return to physical therapy at the earliest possible appointment, as it is imperative to continue with the modalities while undergoing interventional treatments in order to sustain significant and long-term relief.

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Date of Transcription: 01/17/2017

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PATIENT NAME: Falero, Diana
CHART NO.: 20121
OFFICE CHART NO.:
DATE OF SURGERY: 02/03/2017

PREOPERATIVE DIAGNOSIS: Lumbar facet Syndrome

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE: Diagnostic Lumbar Medial Branch Nerve Blocks under fluoroscopic guidance.

LEVEL: L4-L5, L5-S1 Bilateral

SURGEON: Anson Moise, M.D.

ANESTHESIA: TIVA

ANESTHESIOLOGIST: Andrew Boruta, DO

PROCEDURE NOTE: The above noted patient has been seen and has a positive history and physical exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Patient was brought to the procedure room and placed in the prone position. Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaineand 0.25% bupivacaine using 25G 5/8" needle. The level to be accessed was identified under fluoroscopy. Under fluoroscopic guidance in the oblique view, a 22G 5 inch spinal needle advanced to the junction of the transverse process and superior articulating process at the above mentioned levels. Proper needle placement was confirmed in the AP and lateral view. After negative aspiration, 1cc of a combination of 0.25%bupivacaine along with 80mg of methylprednisolone injected at each level mentioned. The patient tolerated procedure well. The procedure was then repeated on the other side.

A&Ox3, VSS, discharged in good & stable condition.

COMPLICATIONS: None.

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Date of Transcription: 02/04/2017

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Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.: 20121
OFFICE CHART NO.:
DATE OF SURGERY: 02/24/2017

PREOPERATIVE DIAGNOSIS: Lumbar facet Syndrome

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Confirmatory Lumbar Medial Branch Nerve Blocks under fluoroscopic guidance.

LEVEL: L4-L5, L5-S1 Bilateral

SURGEON: Anson M. Moise, M.D.

ANESTHESIOLOGIST: Colby Davis, M.D.

PROCEDURE NOTE: The above noted patient has been seen and has a positive history and physical exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Patient was brought to the procedure room and placed in the prone position. Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaine and 0.25% bupivacaine using 25G 5/8" needle. The level to be accessed was identified under fluoroscopy. Under fluoroscopic guidance in the oblique view, a 22G 5 inch spinal needle advanced to the junction of the transverse process and superior articulating process at the above mentioned levels. Proper needle placement was confirmed in the AP and lateral view. After negative aspiration, 1 cc of a combination of 0.25% bupivacaine along with 80mg of methylprednisolone injected at each level mentioned. The patient tolerated procedure well. The procedure was then repeated on the other side.

A&Ox3, VSS, discharged in good & stable condition.

Complications: None

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Date of Transcription: 02/25/2017

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Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.: 20121
OFFICE CHART NO.:
DATE OF SURGERY: 04/10/2017

PREOPERATIVE DIAGNOSES:
1. Lumbar Spondylosis without Myelopathy
2. Lumbar facet Syndrome

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE: Lumbar medial branch nerve radiofrequency ablation under fluoroscopic guidance

LEVEL: L4-5 and L5-S1 bilateral.

SURGEON: Anson Moise, M.D.

ANESTHESIA: TIVA

ANESTHESIOLOGIST: Colby Davis, MD

PROCEDURE NOTE: The above noted patient has been seen and has a positive history and physical exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Patient was brought to the procedure room and placed in the prone position. Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion using betadine. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaine 5 ml using 25G 5/8" needle. The level to be accessed was identified under fluoroscopy. Under fluoroscopic guidance in the oblique view, a 22g 100mm 10 mm active tip RF needle advanced to the above mentioned levels. Final needle position confirmed with PA and Lateral views. Intravascular injection was excluded.

Level: Impedance: Sensory (50HZ): Motor (2 Hz): 3v

All stimulation confined to lower back with verbal confirmation from the patient. After negative

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aspiration, 0.5 cc of a mixture of 1% Lidocaineand 0.25% bupivacaine injected at each level prior to RFA. Lesion: 80 degrees C for 90 seconds. The procedure was repeated on the other side.

The patient tolerated procedure well.

A&Ox3, VSS, discharged in good & stable condition.

COMPLICATION: None.

DISPOSITION: Motor Function was unchanged from prior to the procedure and there was no weakness. The patient was given discharge instructions and discharged home.

COMMENT: The patient tolerated the procedure well and will return in two to four weeks for a follow-up visit to monitor improvement and post-procedural course. The patient understands that there may be one to two weeks of post-rhizotomy inflammation/neuropathy and to treat accordingly with anti-inflammatories (Medrol dose pack, NSAID's, and Tylenol) as well as topical agents, such as cold/heating pads.

Patient was given post-procedure instructions. The patient was instructed to return to physical therapy at the earliest possible appointment, as it is imperative to continue with the modalities while undergoing interventional treatments in order to sustain significant and long-term relief.

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Date of Transcription: 04/11/2017

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54 SOUTH DEAN STREET
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Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.: 20121
OFFICE CHART NO.:
DATE OF SURGERY: 05/01/2017

PREOPERATIVE DIAGNOSIS: Cervical radiculopathy

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Interlaminar Cervical Epidural Steroid Injection Under fluoroscopic guidance, C7-T1

SURGEON: Anson M. Moise, M.D.

ANESTHESIA: MAC

ANESTHESIOLOGIST: Colby Davis, M.D.

The above noted patient has been seen and has a positive history, physical and imaging exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion using betadine. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaine and 0.25% Bupivacaine using 22G 1.5" needle. The level to be accessed was identified under fluoroscopy. An 18g Tuohy needle advanced under fluoroscopic guidance into the epidural space. Epidural space identified by hanging drop technique, and confirmed with lateral view. Intravascular and intrathecal injection was excluded using isovue 2cc. There were no parasthesias during the needle placement. I injected contrast and visualized the borders of epidural space and neuroforamen. After negative aspiration, a 6cc mixture of 2cc (12mg) of betamethasone and 4cc sterile NS injected at the level mentioned. The needle was then withdrawn, flushed with NS and then removed. The patient tolerated procedure well, A&Ox3, VSS, discharged in good & stable condition.

COMPLICATIONS: None.

HEALTH EAST AMBULATORY SURGICAL CENTER
54 SOUTH DEAN STREET
ENGLEWOOD, NJ 07631
Tel: 201-871-0010 Fax: 201-871-0016

Patient was given post-procedure instructions. The patient was instructed to return to physical therapy at the earliest possible appointment, as it is imperative to continue with the modalities while undergoing interventional treatments in order to sustain significant and long-term relief.

This document was electronically signed by Anson Moise on 5/12/2017 12:39:27 AM
Anson M. Moise, M.D.

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HEALTH EAST AMBULATORY SURGICAL CENTER
54 SOUTH DEAN STREET
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Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.: 20121-1
OFFICE CHART NO.:
DATE OF SURGERY: 05/19/2017

PREOPERATIVE DIAGNOSIS: Cervical facet arthropathy

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Diagnostic Cervical medial branch nerve block

LEVEL: C4-C5, C5-C6, Bilateral

SURGEON: Anson M. Moise, M.D.

ANESTHESIOLOGIST: Colby Davis, M.D.

PROCEDURE NOTE: The above noted patient has been seen and has a positive history, physical and imaging exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

In order to better diagnose and treat this patient's spinal pain and related symptoms, it was medically necessary to perform a fluoroscopically guided contrast enhanced nerve blocks themedial branches that innervate the facet joints.

After obtaining informed consent, the patient was positioned prone on the fluoroscopy table and prepped in the usual sterile manner. The area over the paraspinal region overlying the targeted medial branch location was marked. Utilizing a single needle technique and lateral to PA visualization, a 25 g 3 1/2" spinal needle was advanced to the midpoint of the articular pillars of appropriate level. After the absence of vascular uptake or intraforaminal spread was confirmed, 0.5cc of 0.25 % Bupivicaine was injected. Signs and symptoms were monitored for pain reproduction and/or resolution. The procedure was repeated on the medial branches nerves of the other side.

All vital signs were monitored prior to, during and after the procedure. The patient tolerated the procedure well and was discharged after an appropriate period of observation. If there are any

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complications, the patient was instructed to call us. The patient is to follow up with me within one week.

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Anson M. Moise, M.D.

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Date of Transcription: 05/20/2017

PRECISION IMAGING OF NEW YORK

JACOB LICHY, M.D.
THOMAS M. KOLB, M.D.
222 EAST 68TH STREET
NEW YORK, NY 10065

June 17, 2015

RE: FALERO, DIANA
DOB: 2-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MAGNETIC RESONANCE IMAGING OF THE LUMBAR SPINE WITHOUT CONTRAST: 6-11-15

PATIENT HISTORY: Status-post trauma

T1, proton density and T2-weighted sagittal as well as T1 and T2*weighted axial and sagittal images of the lumbar spine were obtained in a closed 1.5 Tesla magnet.

At L5-S1, there is a focal central posterior disc herniation impinging upon the thecal sac narrowing the right-sided neural foramen abutting the exiting the right L5 nerve root.

At L4-5, there is a central posterior disc herniation impinging upon the thecal sac narrowing the neural foramina bilaterally. There is facet hypertrophy at both the L4-5 and L5-S1 levels.

At L3-4, there is a broad disc bulge impinging upon the thecal sac. The neural foramina and exiting nerve roots are unremarkable.

At L1-2, there is a right paracentral disc herniation impinging upon the thecal sac, right lateral recess and inferior aspect of the right-sided neural foramen.

The remainder of the disc levels shows no evidence of bulge or herniation.

There is loss of height of the L5-S1 disc. The remainder of the discs are of normal height.

The marrow signal and conus medullaris are unremarkable. There is no fracture or listhesis.

IMPRESSION: Disc herniations L1-2, L4-5 and L5-S1 with central and foraminal narrowing as detailed above. Disc bulge L3-4.

Thank you for referring this patient to our office.

Sincerely,

Thomas M. Kolb, M.D.

TK/cs
CD sent to above address SJM

PRECISION IMAGING OF NEW YORK

JACOB LICHY, M.D.
THOMAS M. KOLB, M.D.
222 EAST 68TH STREET
NEW YORK, NY 10065

June 17, 2015

RE: FALERO, DIANA
DOB: 2-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MAGNETIC RESONANCE IMAGING OF THE CERVICAL SPINE WITHOUT CONTRAST: 6-11-15

PATIENT HISTORY: Status-post trauma

T1, proton density and T2-weighted sagittal as well as T1 and T2*weighted axial and sagittal images of the cervical spine were obtained in a closed 1.5 Tesla magnet.

At C2-3, there is no disc bulge or herniation. The neural foramina and exiting nerve roots are unremarkable.

At C3-4, there is a focal right foraminal disc herniation impinging upon the right-sided neural foramen.

At C4-5, there is a central posterior disc herniation impinging upon the thecal sac narrowing the neural foramina bilaterally.

At C5-6, there is a central posterior disc herniation impinging upon the thecal sac narrowing the neural foramina bilaterally, left greater than right.

At C6-7, there is a central posterior disc herniation impinging upon the thecal sac narrowing the neural foramina bilaterally.

The discs are of normal height. The marrow signal and cord signal are normal. The cranio-cervical junction is unremarkable. There is no fracture or listhesis.

IMPRESSION: Disc herniations C3-4, C4-5, C5-6 and C6-7 with central and foraminal narrowing as detailed above.

Thank you for referring this patient to our office.

Sincerely,

Thomas M. Kolb, M.D.

TK/cs
CD sent to above address SJM

PRECISION IMAGING OF NEW YORK

JACOB LICHY, M.D.
THOMAS M. KOLB, M.D.
222 EAST 68TH STREET
NEW YORK, NY 10065

July 22, 2015

RE: FALERO, DIANA
DOB: 2-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MAGNETIC RESONANCE IMAGING OF THE RIGHT HIP WITHOUT CONTRAST:
7-20-15

PATIENT HISTORY: Status-post trauma

T1 and T2 fast spin echo sagittal, T2 fast spin echo axial and T1 and T2 fast spin echo coronal images of the hip were obtained in a closed 1.5 Tesla magnet.

The marrow signal is normal with no fracture or osteochondral lesion.

There is a normal sphericity of the femoral head.

There are degenerative changes with narrowing of the femoro-acetabular joint space.

There is a small amount of fluid outlining the inferior femoro-acetabular labrum, which is suspicious for a tear. Clinical correlation is in order. The remainder of the labrum is intact.

Insertions of the anterior and posterior abductor and adductor musculature are unremarkable.

There are no soft tissue masses or fluid collections.

IMPRESSION: Degenerative changes. Suspicion of a tear of the inferior femoro-acetabular labrum as detailed above. Joint effusion.

Thank you for referring this patient to our office.

Sincerely,

Thomas M. Kolb, M.D.

TK/cs
CD sent to above address
SJM

PRECISION IMAGING OF NEW YORK

JACOB LIGHY, M.D.
THOMAS M. KOLB, M.D.
222 EAST 68TH STREET
NEW YORK, NY 10065

July 22, 2015

RE: FALERO, DIANA
DOB: 2-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MAGNETIC RESONANCE IMAGING OF THE LEFT HIP WITHOUT CONTRAST:
7-20-15

PATIENT HISTORY: Status-post trauma

T1 and T2 fast spin echo sagittal, T2 fast spin echo axial and T1 and T2 fast spin echo coronal images of the hip were obtained in a closed 1.5 Tesla magnet.

There is a mild tear of the superolateral femoro-acetabular labrum with associated joint effusion. The remainder of the labrum is unremarkable.

The marrow signal is normal with no fracture or osteochondral lesion.

There is normal sphericity of the femoral head.

There are degenerative changes with significant narrowing of the femoro-acetabular joint with femoro-acetabular cartilaginous defect at its mid inferior aspect.

There is a partial tear of the insertion of the gluteus medius tendon. The remainder of the anterior and posterior abductor and adductor musculature are unremarkable.

There are no soft tissue masses.

IMPRESSION: Partial tear of the gluteus medius tendon. Tear the superolateral femoro-acetabular labrum. Degenerative changes at the femoro-acetabular joint. Small joint effusion.

Thank you for referring this patient to our office.

Sincerely,

Thomas M. Kolb, M.D.

TK/cs
CD sent to above address
SJM

PRECISION IMAGING OF NEW YORK

JACOB LICHY, M.D.
THOMAS M. KOLB, M.D.
222 EAST 68TH STREET
NEW YORK, NY 10065

July 28, 2015

RE: FALERO, DIANA
DOB: 2-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MAGNETIC RESONANCE IMAGING OF THE LEFT KNEE WITHOUT CONTRAST:
7-27-15

PATIENT HISTORY: Status-post trauma

Axial fat-saturated, proton density, fast spin echo, sagittal proton density, fast spin echo and sagittal inversion recovery and coronal gradient echo images were obtained in a closed 1.5 Tesla magnet. Additional meniscal windows were utilized.

There is a flap tear of the posterior horn of the medial meniscus (image 7, sagittal). There is a contusion of the posterior aspect of the medial femoral condyle. The cruciate ligaments are intact. The lateral meniscus is normal. The collateral ligaments are unremarkable. The remainder of the bony structures are unremarkable.

IMPRESSION: Contusion of the posterior aspect of the medial femoral condyle. Flap tear of the posterior horn of the medial meniscus.

Thank you for referring this patient to our office.

Sincerely,

Jacob Lichy, M.D.

JL/cs
CD sent to above address
SJM

PRECISION IMAGING OF NEW YORK

JACOB LICHY, M.D.
THOMAS M. KOLB, M.D.
222 EAST 68TH STREET
NEW YORK, NY 10065

July 28, 2015

RE: FALERO, DIANA
DOB: 2-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MAGNETIC RESONANCE IMAGING OF THE RIGHT SHOULDER WITHOUT CONTRAST: 7-27-15

PATIENT HISTORY: Status-post trauma

Proton density, fat-saturated fast spin echo and T2-weighted fast spin echo, coronal oblique images as well as T2 gradient echo axial and T2 fast spin echo and proton density, fat-saturated fast spin echo, sagittal oblique images were obtained in a closed 1.5 Tesla magnet.

There is hypertrophy at the acromio-clavicular joint. There is a vertical incomplete tear of the supraspinatus tendon. There is also a partial thickness tear of the subscapularis insertion. The infraspinatus tendon is normal. There is anterior dislocation of the biceps tendon. There is fluid in the biceps tendon sleeve. The glenoid labrum is intact.

IMPRESSION: Anterior dislocation of the biceps tendon. Partial thickness tear of the supraspinatus and subscapularis tendons

Thank you for referring this patient to our office.

Sincerely,

Jacob Lichy, M.D.

JL/cs
CD sent to above address
SJM

PRECISION IMAGING OF NEW YORK

JACOB LICHY, M.D.
222 EAST 68TH STREET
NEW YORK, NY 10065

March 14, 2016

RE: FALERO, DIANA
DOB: 2-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MRI OF THE LEFT SHOULDER: 3-03-16

PATIENT HISTORY: Status-post trauma

TECHNIQUE: T1, T2 and proton density axial, coronal and sagittal images were obtained in an ultra high strength 3.0 Tesla large bore magnet. Additional windowing is used.

There is an articular side insertional tear of the supraspinatus tendon as well as a supraspinatus articular side tear at the musculotendinous junction (coronal 11 T2). There is a SLAP tear (13 coronal). There is a partial tear of the biceps muscle and tendon just below the humeral head (sagittal 8, coronal 15). There is mild hypertrophy of the acromioclavicular joint. There is a small contusion of the humeral head posterolaterally (axial 11). There is an insertional tear of the subscapularis tendon (11 axial). The infraspinatus tendon is normal. There is fluid in the axillary pouch.

IMPRESSION: Supraspinatus and subscapularis tendon tears. Small contusion of the humeral head with underlying edema. Labral tears. SLAP tear. Hypertrophy of the acromioclavicular joint. Partial tear of the biceps muscle and tendon.

Thank you for referring this patient to our office.

Sincerely,

Jacob Lichy, M.D.

JL/cs
CD sent to above address CH

Jacob Lichy, M.D.

PRECISION RADIOLOGY
BY JACOB LICHY, M.D.P.C
333 East 68th Street
New York, NY 10065

David R. Payne, M.D.

August 16, 2016

RE: FALERO, DIANA
DOB: 02-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MRI OF THE LEFT FOOT: 8-11-16

PATIENT HISTORY: Status-post trauma

TECHNIQUE: Axial, coronal and sagittal proton density water-weighted and fat-weighted views were obtained in an ultra high strength 3.0 Tesla large bore magnet.

There is postoperative change in the 1st metatarsal. There is a residual hallux valgus deformity. The sesamoids are laterally subluxed. There is metatarsosesamoid osteoarthritis. There are 2nd through 4th digit hammertoes and there is a lateral tilt and subluxation of 2nd and 3rd proximal phalanges, as well as medial tilt and subluxation of the 4th and 5th proximal phalanges. There is 2nd through 5th metatarsophalangeal joint osteoarthritis. There is mild interphalangeal joint arthritis. There is mild tarsometatarsal osteoarthritis. The Lisfranc ligament is intact. Subtalar articulations are unremarkable. Inserting ankle tendons are intact. Collateral ligaments at the ankle level are outside the field of view. Musculature and tendons intrinsic to the forefoot and midfoot are remarkable. There is a neuroma at the 2nd interspace of 1.5 centimeters in length.

IMPRESSION:
Postoperative changes of the 1st metatarsal with residual hallux valgus deformity.
Osteoarthritis at 1st metatarsophalangeal joint, as well as at metatarsosesamoid articulations.
2nd through 5th digit hammertoes with laterally tilted and subluxed 2nd and 3rd digits and medially tilted and subluxed 4th and 5th digits.

Continued on page 2

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Jacob Lichy, M.D.

PRECISION RADIOLOGY
BY JACOB LICHY, M.D.,P.C.
222 EAST 68TH STREET
NEW YORK, NY 10065

David R. Payne, M.D.

August 16, 2016

RE: FALERO, DIANA
DOB: 02-08-50

IMPRESSION CONTINUED:
Moderate 2nd through 5th metatarsophalangeal joint osteoarthritis.
Mild tarsometatarsal osteoarthritis.
2nd interspace neuroma, as described.
Intact ankle tendons and ligaments as visualized.

Thank you for the courtesy of this referral.

Sincerely,

David R. Payne, M.D.
Diplomate, American Board of Radiology, with Added Qualifications in Neuroradiology
DRP/cms
CD sent to above address CH

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Jacob Lichy, M.D.

PRECISION RADIOLOGY
BY JACOB LICHY, M.D.P.C
222 EAST 68TH STREET
NEW YORK, NY 10065

David R. Payne, M.D.

August 30, 2016

RE: FALERO, DIANA
DOB: 02-08-50

Charles Kaplan, M.D.
100A Livingston Street
Brooklyn, New York 11201

Dear Dr. Kaplan:

MRI OF THE RIGHT KNEE: 8-28-16

PATIENT HISTORY: Status-post trauma.

TECHNIQUE: Axial, coronal and sagittal proton density water-weighted and fat-weighted images were obtained in an ultra high strength 3.0 Tesla large bore magnet.

There is a contusion of the medial femoral condyle with a roughly 1.0 centimeter area of cancellous edema. There is a tear of the posterior horn of the medial meniscus just below the area of cancellous edema (9 and 10 sagittal). There is a tear of the anterior horn of the medial meniscus and a compression fracture of the anterior aspect of the medial femoral condyle. There is a strain of the anterior cruciate ligament (15 sagittal). There is a partial tear of the proximal medial head of the gastrocnemius with a suggestion of intermuscular hemorrhage (10 axial, 7 sagittal).

IMPRESSION: Compression fracture of the anterior medial femoral condyle. Contusions of the medial femoral condyle. Tears of the medial meniscus as described above. Partial tear of the anterior cruciate ligament. Clinical correlation for anterior cruciate ligament tear findings is recommended. The appearance of the anterior cruciate ligament may be due to age changes ("celery stalk" anterior cruciate ligament). Partial tear of the medial head of the gastrocnemius.

Thank you for referring this patient to our office.

Sincerely,

Jacob Lichy, M.D.

JL/cms
CD sent to above address CH

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HEALTH EAST
MEDICAL GROUP
888 . MED . 7474
www.healtheastmedicalgroup.com info@healtheastmedicalgroup.com

DOS: 06/08/2017

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Follow Up Evaluation

HPI: Ms. Falero is being treated in our pain management office for cervical and lumbar radiculopathy and facet syndrome that has been responsive to pain management intervention. The patient most recently had a cervical MBB diagnostic bilateral C4 to C6 on May 19, 2017. The patient states she had 100% pain relief for one week, but pain returned and is now 8/10 today with pain radiating to her left upper extremity. The patient states back pain was aggravated yesterday after grocery shopping and is now 7/10 today and the patient has not started physical therapy after lumbar RFA that was done on April 10, 2017.

PHYSICAL EXAMINATION: Lumbar exam: Tenderness over lumbar spine. Negative straight leg raise bilaterally. Flexion 0 to 30, lateral rotation 0 to 20 bilaterally, lateral bending 0 to 15, extension 0 to 5. Deep tendon reflexes, hyperreflexia bilaterally. Negative clonus. Cervical exam: Tenderness over C-spine and trapezius muscle. Injection site is clean and dry, and non-indurated. Negative Spurling bilaterally. Flexion 0 to 30, extension 0 to 20, lateral rotation 0 to 35 bilaterally. Deep tendon reflexes, positive hyperreflexia bilaterally.

ASSESSMENT AND PLAN: Patient with lumbar radiculopathy, needs to start physical therapy and cervical radiculopathy, the patient needs to proceed with cervical MBB confirmatory to assess for RFA. The patient may follow up with scheduled appointment or earlier if symptoms become worse.

This document was electronically signed by Roderick James on 6/14/2017 9:07:08 AM
Roderick James, P.A.
Anson Moise, M.D.
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Date of Dictation: 06/08/2017
Date of Transcription: 06/09/2017

HEALTH EAST AMBULATORY SURGICAL CENTER
54 SOUTH DEAN STREET
ENGLEWOOD, NJ 07631
Tel: 201-871-0010 Fax: 201-871-0016

REPORT OF OPERATION

Patient Name:	Falero, Diana
MRN:	20121
Date of Birth:	02/08/1950
Date of Procedure:	12/06/2016
Date of Dictation:	12/06/2016
Procedure:	1. Left knee examination under anesthesia, left knee arthroscopy, partial medial meniscectomy. 2. Partial lateral meniscectomy. 3. Extensive synovectomy. 4. Chondroplasty.
Surgeon:	David R. Capiola, M.D.
Assistant:	Barry Hughes, P.A.
Anesthesiologist:	Harold Delaleu
Type of Anesthesia:	General
Pre-Op. DX:	Left knee medial and lateral meniscal tears, synovitis, and chondromalacia.
Post-Op. DX:	Left knee medial and lateral meniscal tears, synovitis, and chondromalacia.
Estimated Blood Loss:	Minimal.
Blood Replacements:	None.
IV fluids:	Lactated Ringer's.
Specimens:	None.
Wound:	Clean.
Complications:	None.

INDICATION FOR THE PROCEDURE: After operative site was verified and operative consent was obtained, the patient was brought to the operating room where LMA anesthesia was administered in the usual fashion. Preoperative antibiotics were administered prior to and after the case. Examination under anesthesia of the left lower extremity demonstrated crepitus with flexion and extension with a stable knee. The left lower extremity was prepped and draped in the usual sterile fashion and after an adequate time-out was performed involving the attending surgeon, anesthesiologist and a circulating nurse, an inferolateral portal site was established followed soon by an inferomedial portal site and a diagnostic arthroscopy was performed. There was found to be extensive synovitis and a synovectomy was performed for postoperative pain relief and for better visualization. There was found to be chondromalacia grade 3 changes on the undersurface of the patella and a chondroplasty was performed using electrocautery as well as

HEALTH EAST AMBULATORY SURGICAL CENTER
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the shaver. The medial and the lateral gutters were entered. There was found to be extensive synovitis and a synovectomy was performed as well. The trochlea demonstrated significant chondral damage as well, and a chondroplasty was performed for the unstable flaps of cartilage. The medial joint was entered. There was found to be tearing of the posterior horn of the medial meniscus. A partial meniscectomy was performed utilizing arthroscopic biters, shaver and electrocautery. The intercondylar notch was entered and extensive synovectomy was performed. The ACL was probed in its entirety and was found to be intact. The lateral joint was entered. There was found to be significant tearing involving the posterior horn and body of the lateral meniscus extending into the anterior horn. A partial meniscectomy was performed utilizing arthroscopic biters and shaver. Electrocautery was used to seal the edges. The knee was copiously irrigated. The portal sites were closed. A sterile dressing was placed. The patient was awakened and transferred to the PACU in stable condition. No complications were noted.

David R. Capiola, M.D.

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HEALTH EAST AMBULATORY SURGICAL CENTER
54 SOUTH DEAN STREET
ENGLEWOOD, NJ 07631
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REPORT OF OPERATION

Patient Name:	Falero, Diana
MRN:	20120
Date of Birth:	02/08/1950
Date of Procedure:	03/16/2017
Date of Dictation:	03/16/2017
Procedure:	1. Right knee arthroscopy. 2. Arthroscopic partial medial meniscectomy. 3. Partial lateral meniscectomy. 4. Chondroplasty of lateral tibial plateau and trochlea, patella with extensive synovectomy.
Surgeon:	Thomas A. Scilaris, M.D.
Assistant:	Richard Cohen, P.A. and Barry Hughes, P.A.
Anesthesiologist:	Dr. Boruta.
Type of Anesthesia:	Popliteal saphenous block right lower extremity with General
Pre-Op. DX:	Right knee medial meniscal tear.
Post-Op. DX:	1. Right knee posterior horn medial meniscal tear. 2. Lateral meniscal tear. 3. Chondromalacia patella, lateral tibial plateau and synovitis.
Complications:	None.
Condition:	Stable to the recovery room.

PROCEDURE: The patient was brought to the operating room today for the above-mentioned procedures. Risks and benefits were discussed with the patient. Informed consent was signed, no guarantees given. The patient was brought to the operating room and a given a time-out was performed, the right leg was marked, the patient was given a popliteal saphenous block followed by an LMA and given 2 g of Ancef, a straight anterior lateral portal was made under direct visualization. An anterior medial portal was made. Upon inspection of the medial compartment of the knee, posterior horn of medial meniscus was visualized. Inner 25% tear was found to be noted this was debrided with straight biter, shaver, and ArthroCare probe. After this was taken back to stable meniscal rim, the medial femoral condyle and plateaus revealed some mild chondromalacia. The anterior and posterior cruciate ligaments were probed and found to be stable. The lateral meniscus revealed inner 35% tear with concomitant chondral defect along the tibial plateau grade 3 lesion measuring about 8 mm in diameter. This was stabilized with the shaver and ArthroCare probe. Attention was paid to the patellofemoral joint, an extensive synovectomy was performed and after this was debrided, there was a tear noted and chondromalacia along the trochlea and along the patella itself, after this was stabilized, patellar tracking was within normal limits. There were no loose bodies. 3-0 Monocryl sutures were then

HEALTH EAST AMBULATORY SURGICAL CENTER
54 SOUTH DEAN STREET
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placed followed by a sterile dressing and the patient was taken to the recovery room in stable condition.

Thomas A. Scilaris, M.D.

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Date of Dictation: 03/16/2017
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HEALTH EAST AMBULATORY SURGICAL CENTER
54 SOUTH DEAN STREET
ENGLEWOOD, NJ 07631
Tel: 201-871-0010 Fax: 201-871-0016

REPORT OF OPERATION

Patient Name:	Falero, Diana
MRN:	20120
Date of Birth:	02/08/1950
Date of Procedure:	03/16/2017
Date of Dictation:	03/16/2017
Procedure:	1. Right knee arthroscopy. 2. Arthroscopic partial medial meniscectomy. 3. Partial lateral meniscectomy. 4. Chondroplasty of lateral tibial plateau and trochlea, patella with extensive synovectomy.
Surgeon:	Thomas A. Scilaris, M.D.
Assistant:	Richard Cohen, P.A. and Barry Hughes, P.A.
Anesthesiologist:	Dr. Boruta.
Type of Anesthesia:	Popliteal saphenous block right lower extremity with General
Pre-Op. DX:	Right knee medial meniscal tear.
Post-Op. DX:	1. Right knee posterior horn medial meniscal tear. 2. Lateral meniscal tear. 3. Chondromalacia patella, lateral tibial plateau and synovitis.
Complications:	None.
Condition:	Stable to the recovery room.

PROCEDURE: The patient was brought to the operating room today for the above-mentioned procedures. Risks and benefits were discussed with the patient. Informed consent was signed, no guarantees given. The patient was brought to the operating room and a given a time-out was performed, the right leg was marked, the patient was given a popliteal saphenous block followed by an LMA and given 2 g of Ancef, a straight anterior lateral portal was made under direct visualization. An anterior medial portal was made. Upon inspection of the medial compartment of the knee, posterior horn of medial meniscus was visualized. Inner 25% tear was found to be noted this was debrided with straight biter, shaver, and ArthroCare probe. After this was taken back to stable meniscal rim, the medial femoral condyle and plateaus revealed some mild chondromalacia. The anterior and posterior cruciate ligaments were probed and found to be stable. The lateral meniscus revealed inner 35% tear with concomitant chondral defect along the tibial plateau grade 3 lesion measuring about 8 mm in diameter. This was stabilized with the shaver and ArthroCare probe. Attention was paid to the patellofemoral joint, an extensive synovectomy was performed and after this was debrided, there was a tear noted and chondromalacia along the trochlea and along the patella itself, after this was stabilized, patellar tracking was within normal limits. There were no loose bodies. 3-0 Monocryl sutures were then

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placed followed by a sterile dressing and the patient was taken to the recovery room in stable condition.

Thomas A. Scilaris, M.D.

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Date of Transcription: 03/17/2017

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DOS:10/01/2015

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Initial Evaluation

HPI: Ms. Falero is a 65-year-old female who was a victim of a motor vehicle accident that occurred on May 4, 2015, where while walking a Dominos delivery truck that was parked had stock trays filled with dough that accidentally fell onto the patient as she was walking by and knocking her down to the ground. As a direct result of the accident she sustained injuries to her neck and mid back, low back, right shoulder, bilateral knees and hips. She was taken to Kings County Hospital where she was seen, evaluated and later released. Since then she has gone through comprehensive conservative pain management course including physical therapy with modalities. She is being seen in the pain office specifically for her neck and back complaints which have been intractable to these treatments. She presents to the office complaining of 8 to 9/10 cramping pain in the lower back with dysesthesias that shoot down to the soles of her feet. However, there is an aching spasmodic component exacerbated by getting out of chairs or standing for extended periods of time. This is associated with numbness. The pain in the neck is 7 to 8/10 with dysesthesias that shoot into the shoulders. There is numbness in the hands laterally exacerbated by lateral rotation and extension. She experiences intermittent episodes of occipital headaches as well that can occur without any exacerbator or alleviator. Her past pain history is significant for degenerative disc disease as well as herniated nucleus pulposus in the neck and lower back to which she has been receiving treatment. She also has a history of fibromyalgia for which she is currently treating.

PAST MEDICAL HISTORY: Significant for hypertension, hypercholesterolemia, fibromyalgia and osteoarthritis. She also has a history of bursitis.

PAST SURGICAL HISTORY: Significant for foot surgery and tubal ligation.

ALLERGIES: She has no known drug allergies.

MEDICATIONS: Include morphine 60 mg 3 times a day, Zoloft, Zocor, amlodipine, meloxicam, and Robaxin.

REVIEW OF SYSTEMS: Per the HPI is significant for pain, limited mobility, tightness, spasm, paresthesias, and dysesthesias. Negative for nausea, vomiting, fevers, chills, diarrhea, constipation, bowel or bladder incontinence, chest pain, difficulty breathing and night sweats. All other systems are negative.

PHYSICAL EXAMINATION: This is a well-developed, well-nourished female appearing her stated age in no acute respiratory distress. Her head is normocephalic and atraumatic. Her mucous membranes are moist. Her neck is supple with no obvious masses. Respirations are non-labored. Capillary refill is less than 2 seconds. Her abdomen is soft and nontender. She has a slow and antalgic gait with difficulty getting onto and off of the exam table. Paraspinous muscle tenderness is appreciable exquisitely into the cervical, thoracic and lumbosacral spines. Positive intertrochanteric bursal tenderness is appreciable bilaterally. Negative Faber's. Straight leg raise is positive bilaterally. The extremity exam is deferred to the orthopedist and her physiatrist. Decreased triceps tendon reflex on the right, decreased Achilles tendon reflexes bilaterally with no signs of atrophy. No costovertebral angle tenderness. No spinous process tenderness. No piriformis muscle tenderness. Flexion of the cervical spine is 30 degrees, extension is 10 degrees, tilt to the left is 10 degrees, tilt to the right is 10 degrees. Rotation is 20 to the left and 15 to the right. Lumbar spine flexion is 20 degrees, extension is 3 degrees, tilt is 5 degrees bilaterally. Straight leg raising is positive bilaterally. 5-/5 motor strength appreciable in the distal lower extremities. 5-/5 motor strength appreciable in the right upper extremity proximally. She is awake, alert and oriented x3 with a normal affect. Facet loading is appreciable bilaterally.

DIAGNOSTIC STUDIES: She had an MRI of the cervical spine on June 17, 2015 that showed disc herniation at C3-C4, C4-C5, C5-C6 and C6-C7 with central and foraminal narrowing. MRI of the lumbosacral spine on June 17, 2015 showed disc herniations at L1-L2, L4-L5 and L5-S1 with central and foraminal narrowing. Disc bulge at L3-L4. She had EMG NCV of the upper extremity on 09/01/2015 that shows left cervical radiculopathy. EMG NCV of the lower extremity on August 4, 2015 showed bilateral lumbar radiculopathy, left peroneal motor neuropathy and mild left sural sensory neuropathy.

ASSESSMENT AND PLAN: Ms. Falero is suffering from a cervical radiculopathy, lumbar radiculopathy, lumbar facet arthropathy among other injuries she sustained from an accident that occurred on May 4, 2015. The risks, benefits and alternatives of the care plan were discussed with the patient. All questions were answered thoroughly and she agreed to proceed with cervical epidural steroid injection under fluoroscopic guidance and anesthesia. She understands repeat injection may be required in order to achieve optimal pain control. She will under lumbar epidural steroid injection for the lumbar radiculopathy as well. For management of facet

arthropathy, she agreed to proceed with medial branch nerve block. Should she have a positive medial branch nerve block, she will be a candidate for medial branch nerve radiofrequency ablation. She will follow up with her physiatrist regarding the extremity complaints. She will also continue with her conservative management while undergoing these treatments. She will return to the office following the procedure, but understands that should her symptoms worsen or her condition changes in anyway, she could return to the office sooner.

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DOS:03/17/2016

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Follow Up Evaluation

HPI: Ms. Falero has been treating in the pain office for cervical radiculopathy, lumbar radiculopathy, lumbar facet syndrome, and myofascial pain syndrome she developed from an accident that occurred on May 4, 2015. We have been awaiting proceeding with pain management interventions, particularly epidural injections and nerve blocks. Unfortunately, she has been unable to get these procedures verified and authorized and in the meantime continues to complain of 7 to 8 out of 10 pain in the neck and 8 to 9 out of 10 pain in the lower back which is unchanged from previous visit. It is associated with dysesthesias into the shoulders coming from the neck as well as pain that shoots down into the soles of bilateral feet coming from her lower back.

PHYSICAL EXAMINATION: The extremity exam is deferred to her treating physician. Slow and antalgic gait, difficultly getting onto and off the exam table. Paraspinous muscle tenderness is appreciable in cervical, thoracic, and lumbar regions as well as trigger points appreciable in bilateral trapezius muscles. Straight leg raise positive bilaterally. Decreased triceps tendon reflex on the right. Decreased Achilles tendon reflexes bilaterally. Facet loading is appreciable bilaterally. Straight leg raise is positive bilaterally. Cervical flexion is 30 degrees, extension 10 degrees. Lumbar flexion is 20 degrees, extension 5 degrees, tilt and rotation 5 degrees.

ASSESSMENT AND PLAN: We continue to await authorization to proceed with medically necessary cervical epidural injections, lumbar epidural injections, as well as diagnostic medial branch nerve blocks. In the meantime, she will continue with physical therapy and medication previously prescribed. She will return to the office in 10 to 12 weeks; however, she understands that should her symptoms worsen or her condition change or we obtain approval for these medically necessary procedures, she could return to the office sooner.

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Date of Transcription: 03/18/2016

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DOS:07/14/2016

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Follow Up Evaluation

HPI: Ms. Falero has been treating in the pain office for cervical radiculopathy, lumbar radiculopathy, facet syndrome, and myofascial pain syndrome, which developed from an accident that occurred on May 4, 2015. She has undergone trigger point injections with Dr. Kaplan, which provided benefit in spasmodic components of her pain all being transient. She continues to complain of pain in the neck, it was radicular in nature with dysesthesia into the shoulders as well as low back pain with numbness and burning into the soles of the feet.

PHYSICAL EXAMINATION: The extremity exam is deferred to her physiatrist. She has a Slow and antalgic gait requiring a cane to assist with ambulation. It is difficulty getting onto and off the exam table. Paraspinous muscle tenderness is appreciable on the cervical, thoracic, and lumbar regions with trigger point. Straight leg raising is positive bilaterally. Decreased triceps tendon on the right. Decreased Achilles tendon reflex bilaterally. Facet loading is appreciable bilaterally. Cervical flexion is 35. Extension is 12. Tilt is 20 degrees bilaterally. Rotation is 30 degrees to the left and 40 degrees to the right. Lumbar flexion is 30 degrees. Extension is 10. Tilt and rotation are 10 degrees bilaterally.

ASSESSMENT AND PLAN: We will start pain management interventions particularly cervical and lumbar epidural steroid injection under fluoroscopic guidance and anesthesia. She understands repeat injection maybe required in order to achieve optimal pain control. She will return to the office following the procedure, but understands that should her symptoms worsen or her condition changes in anyway, she could return to the office sooner. She reports that she is currently utilizing Morphine 60 mg three times a day. She was advised to consider a weaning protocol to discuss with the treating physician who is prescribing the pain mediations. She will discuss with the physician and we will further discuss and followup.

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Date of Transcription: 07/14/2016

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DOS: 12/01/2016

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Follow Up Evaluation

HPI: Ms. Falero has been treating in the pain office for cervical and lumbar radiculopathy and facet syndrome which had been intractable to conservative management and result of injury from May 4, 2014 and has been intractable to conservative management. She has been responsive to pain management injection that she underwent a cervical and caudal epidural steroid injection on November 11, 2016 and October 28, 2016 respectively. She reports greater than 90% relief in both aching and spasmodic pain and dysesthesia and numbness in both the neck and back since the injection.

PHYSICAL EXAMINATION: The extremity exam is deferred. She has slow and antalgic gait requiring a cane to assist with ambulation. Spurling sign is positive. Cervical flexion is 50 degrees. Flexion is 50 degrees. Tilt is 30 degrees bilaterally. Rotation is 60 degrees to the left and 50 degrees to the right. Lumbar flexion is 40 degrees. Extension is 12 degrees. Tilt and rotation are 10 and 12 degrees bilaterally respectively. Decreased triceps tendon reflex on the right.

ASSESSMENT AND PLAN: We will continue with intervention by repeating cervical and caudal epidural steroid injection. She will follow with her physiatrist regarding extremity complaints. She will return to the office following the procedure, but understands that should her symptoms worsen or her condition changes in anyway, she could return to the office sooner.

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DOS: 01/12/2017

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Follow Up Evaluation

HPI: Mrs. Falero has been treated in the Pain Management Clinic for cervical and lumbar spine radiculopathy and facet syndrome which has been intractable to conservative management. Recently, she has received caudal injection on December 28, 2016 and had 90% relief for about 2 weeks, pain returned a week ago after she tried to do some house chores and which included some bending. The patient is also scheduled for cervical epidural injections on January 16, 2017 and today her pain level for the back is at 4 and the neck remains at 4 as well.

PHYSICAL EXAMINATION: Lumbar physical exam, the patient ambulates with cane with antalgic gait. Neck exam, decreased flexion and lateral rotation, lateral bending 0-10 with pain, positive Spurling bilaterally. Lumbar flexion 0 to 20 with pain and extension 0 to 10 with pain. Lateral bending on lumbar is 0 to 10 degrees with pain bilaterally.

ASSESSMENT AND PLAN: Will continue cervical epidural injection scheduled for January 16, 2017 and for lumbar will continue with physical therapy and will start with medial branch block diagnostic to assess for RFA. The patient may continue follow up with her orthopedist regarding right knee pain. She may follow up with this office in two weeks after cervical epidural injection. We will also request for medial branch block diagnostic block. The patient may return to office sooner if condition worsens.

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Roderick James, P.A.
Anson Moise, M.D.

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Date of Transcription: 01/13/2017

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DOS: 02/16/2017

RE: Falero, Diana
CHART #: 20121
DOB: 02/08/1950
DOI: 05/04/2015

Follow Up Evaluation

HPI: Ms. Falero has been treated in the Pain Management Clinic for cervical and lumbar radiculopathy and facet syndrome, which has been intractable to conservative management. Recently, she has received medial branch block diagnostic at L4, S1 and states that she has been pain free since the injection. The patient states a mild trapezius pain bilaterally. Pain scale for low back is 5/10 and neck is 5/10.

PHYSICAL EXAMINATION: Lumbar Exam: Tenderness over lumbar spine. The patient ambulates with a cane and has antalgic gait. Flexion 0 to 30 degrees with pain. Lateral bending 0 to 10 degrees with pain bilaterally. Lateral rotation 0 to 30 degrees bilaterally. Deep tendon reflexes 2+. Negative straight leg raise. Cervical Exam: C-spine nontender. Negative Spurling's. Flexion 0 to 40. Extension 0 to 20. Lateral rotation 0 to 40 bilaterally. Negative Spurling's.

ASSESSMENT AND PLAN: We will request to begin physical therapy. For lumbar radiculopathy, given the positive medial branch block diagnostic L4, S1, we will proceed with medial branch block confirmatory at L4, S1. The patient may follow up on scheduled appointment or earlier if symptoms become worse.

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Roderick James, P.A.
Anton Moise, M.D.

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Date of Dictation: 02/16/2017
Date of Transcription: 02/17/2017

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Tel: 201-871-0010 Fax: 201-871-0016

PATIENT NAME: Falero, Diana
CHART NO.: 20121
OFFICE CHART NO.:
DATE OF SURGERY: 02/24/2017

PREOPERATIVE DIAGNOSIS: Lumbar facet Syndrome

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Confirmatory Lumbar Medial Branch Nerve Blocks under fluoroscopic guidance.

LEVEL: L4-L5, L5-S1 Bilateral

SURGEON: Anson M. Moise, M.D.

ANESTHESIOLOGIST: Colby Davis, M.D.

PROCEDURE NOTE: The above noted patient has been seen and has a positive history and physical exam. The above noted diagnoses have been established and the patient has failed basic non-invasive conservative treatment. The different options both non-surgical/surgical and risks benefits have been explained in simple laymen's terms to the patient including complications such as bleeding, allergic reaction, infection and other complications up to and including death. Informed consent was obtained after the risks, benefits, and alternatives explained to the patient.

Patient was brought to the procedure room and placed in the prone position. Standard ASA monitors were then applied. Confirmation of the procedure was obtained from the patient. The skin overlying the area to be injected was cleaned in a sterile fashion. Sterile drape was placed around the area to be injected. The overlying skin was anesthetized with 1 % Lidocaine and 0.25% bupivacaine using 25G 5/8" needle. The level to be accessed was identified under fluoroscopy. Under fluoroscopic guidance in the oblique view, a 22G 5 inch spinal needle advanced to the junction of the transverse process and superior articulating process at the above mentioned levels. Proper needle placement was confirmed in the AP and lateral view. After negative aspiration, 1 cc of a combination of 0.25% bupivacaine along with 80mg of methylprednisolone injected at each level mentioned. The patient tolerated procedure well. The procedure was then repeated on the other side.

A&Ox3, VSS, discharged in good & stable condition.

Complications: None

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Anson M. Moise, M.D.

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Date of Dictation: 02/24/2017
Date of Transcription: 02/25/2017

PHYSICAL THERAPY DAILY NOTES

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Interventional Spine

PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

05/21/15:
Patient came in for a formalized physical therapy initial evaluation.
S: Patient came in today for physical therapy treatment. She reports pain and stiffness in her neck, lower back, both shoulders, both hips, both knees and both ankles.
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

05/28/15:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

05/29/15:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

06/05/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

06/06/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

06/10/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

06/12/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

06/19/15:
S: Patient came in today for physical therapy treatment

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O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

06/20/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

06/24/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

06/26/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

07/01/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

07/07/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

07/09/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

07/16/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

07/22/15:
S: Patient came in today for physical therapy treatment

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O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

07/24/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

07/29/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

07/31/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

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Interventional Spine

PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

08/06/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

08/11/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

08/13/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

08/18/15:
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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

09/10/15:
S: Patient came in today for physical therapy treatment
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09/22/15:
S: Patient came in today for physical therapy treatment

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09/25/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

10/02/15:
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O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

10/14/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

10/16/15:
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10/24/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

10/27/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

10/30/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

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Foot & Ankle Surgery

PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

11/03/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

11/05/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

11/13/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

12/18/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

12/23/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, ultrasound, and therapeutic exercises, as tolerated

12/30/15:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

01/08/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

01/15/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

01/22/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

01/29/16:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical Therapy Initial Evaluation for complete objective findings and measurements
A: Patient tolerated the treatment well with no c/o pain after physical therapy.

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P: Patient's treatment plan included the following procedures and modalities: cold pack, electrical stimulation, and therapeutic exercises, as tolerated.

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

02/05/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

02/12/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

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S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

03/04/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

03/11/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

03/18/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

03/25/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.

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P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

04/01/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

04/08/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
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P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

04/15/16:
S: Patient came in today for physical therapy treatment
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PHYSICAL MEDICINE DAILY NOTES

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05/06/16:
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05/13/16:
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O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
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P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

05/20/16:
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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

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O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

07/22/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, and therapeutic exercises, as tolerated

07/29/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities, and therapeutic exercises, as tolerated.

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

08/05/16:
S: Patient came in today for physical therapy treatment
O: Please refer to the Physical therapy Initial evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities, and therapeutic exercises, as tolerated

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08/19/16:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical Therapy Initial Evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no c/o pain after physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities and therapeutic exercises, as tolerated.

08/26/16:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical Therapy Initial Evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no c/o pain after physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities and therapeutic exercises, as tolerated.

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PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

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A: Patient tolerated the treatment well with no pain from physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities, and therapeutic exercises, as tolerated

09/09/16:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical Therapy Initial Evaluation for complete objective findings and measurements.
A: Patient tolerated the treatment well with no c/o pain after physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities and therapeutic exercises, as tolerated.

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09/30/16:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical Therapy Initial Evaluation for complete objective findings and measurements
A: Patient tolerated the treatment well with no c/o pain after physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities, and therapeutic exercises, as tolerated.

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REHABILITATION CENTER

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Christopher Kyriakides, D.O
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Thomas Scilaris, M.D.
Orthopaedic Surgery
Board Certified, ABOS

Debra Ibrahim, D.O.
Board Certified – ABPMR

PHYSICAL MEDICINE DAILY NOTES

RE: FALERO, DIANA

10/07/16:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical Therapy Initial Evaluation for complete objective findings and measurements
A: Patient tolerated the treatment well with no c/o pain after physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities, and therapeutic exercises, as tolerated.

10/14/16:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical Therapy Initial Evaluation for complete objective findings and measurements
A: Patient tolerated the treatment well with no c/o pain after physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities, and therapeutic exercises, as tolerated.

10/21/16:
S: Patient came in today for physical therapy treatment.
O: Please refer to the Physical Therapy Initial Evaluation for complete objective findings and measurements
A: Patient tolerated the treatment well with no c/o pain after physical therapy.
P: Patient's treatment plan included the following procedures and modalities: moist heat, electrical stimulation, therapeutic functional activities, and therapeutic exercises, as tolerated.

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PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

11/04/16:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, tightness, and stiffness on her neck and both knees.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities, as tolerated.
Noted: LOM on both knees.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

11/18/16:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and both knees.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities, as tolerated.
Noted: pain with prolonged standing and walking.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

12/02/16:

S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh.

O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.

Noted: painful AROM on L Sh.

A: Patient tolerated the treatment well before, during, and after physical therapy treatment.

P: Continue with the current treatment plan.

12/12/16:

S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh. Patient is s/p Left knee surgery on December 6, 2016.

O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities

Noted: no new changes noted

A: Patient tolerated the treatment well before, during, and after physical therapy treatment.

P: Continue with the current treatment plan.

12/14/16:

S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on lowerback and left knee.

O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities

Noted: no new changes noted

A: Patient tolerated the treatment well before, during, and after physical therapy treatment.

P: Continue with the current treatment plan.

12/16/16:

S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on lowerback and left knee.

O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities

Noted: no new changes noted

A: Patient tolerated the treatment well before, during, and after physical therapy treatment.

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P: Continue with the current treatment plan.

12/19/16:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on lowerback and left knee.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

12/21/16:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on lowerback and left knee.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

12/23/16:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on lowerback and left knee.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

12/27/16:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on lowerback and left knee.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities

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Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

12/29/16:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on lowerback and left knee.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

12/30/16:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on lowerback and left knee.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

01/03/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: painful AROM on L Sh.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/05/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/06/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/09/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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01/11/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/13/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/18/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/19/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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01/20/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/23/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/25/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

01/27/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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01/30/17:

S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.

O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.

Noted: no new changes noted.

A: Patient tolerated the treatment well before, during, and after physical therapy treatment.

P: Continue with the current treatment plan.

01/31/17:

S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.

O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.

Noted: no new changes noted.

A: Patient tolerated the treatment well before, during, and after physical therapy treatment.

P: Continue with the current treatment plan.

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PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

02/06/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: painful AROM on L Sh.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

02/14/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: painful AROM on L Sh.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

02/17/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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02/22/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

02/23/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh.
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

02/27/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain on her neck
O: Treatment procedures and modalities: moist heat, therapeutic exercises, and therapeutic functional activities.
Noted: no new changes noted
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

04/04/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, ultrasound, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

04/06/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, ultrasound, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

04/12/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, ultrasound, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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04/19/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, ultrasound, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

04/21/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, ultrasound, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

04/25/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, ultrasound, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

04/28/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, ultrasound, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

05/02/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

05/05/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

05/09/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

05/12/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

SPINE & ORTHOPAEDIC
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05/16/17:
S: Patient came in today for physical therapy treatment. Pt. c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

05/18/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

05/22/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

05/26/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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SPINE & ORTHOPAEDIC
REHABILITATION CENTER

PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

06/01/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

06/02/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

06/06/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

06/09/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.

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P: Continue with the current treatment plan.
06/12/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

06/23/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

06/30/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

07/06/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

07/14/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

07/21/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

07/27/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.

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P: Continue with the current treatment plan.

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PHYSICAL THERAPY DAILY NOTES

RE: FALERO, DIANA

08/03/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

08/11/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

08/18/17:
S: Patient came in today for physical therapy treatment. Pt. still c/o pain, and soreness on L Sh and left knee.
O: Treatment procedures and modalities: moist heat, electrical stimulation, therapeutic exercises, and therapeutic functional activities.
Noted: full ROM on left knee.
A: Patient tolerated the treatment well before, during, and after physical therapy treatment.
P: Continue with the current treatment plan.

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